LAWS AND HEALTH CARE PROVIDERS

A Study of Legislation and Legal Aspects of Health Care Delivery

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CONTENTS

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1. INTRODUCTION AND METHODOLOGY

Legislation are important for the simple reason that they, in a specific manner, operationalise policies of the government. For that matter, the legislation is only one part of the policy literature available for undertaking policy analysis. This does not mean that the legislation always follows the policy. There are instances when the legislation (the law or ordinances) are passed first, giving an indication of the policy being pursued by the state. There are also instances, numerous in the field of health care, when no legislation follow the announced policy and thereby, leaving the implementation of the announced policy at the discretion of the administrators and the political environment prevalent. Thus, the legislation cannot be looked at in vacuum, they must be understood in relation to policies.

The legislation being part of the policy, they also originate as well as take actual course in the concrete reality of politics. The legislation, therefore, show the intention of operationalisation, not always the real operationalisation of policies. For the mere existence of law does not automatically lead to its implementation. For the laws enacted may not be acted upon. Or if acted upon, the same may be done in superficial and improper manner. Not only that, the radical policy could follow by a radical sounding legislation, but the provision of law is kept so vague or the loopholes kept so that the powerful forces effectively thwart the actual implementation.

The legislation also brings into picture the judiciary. While simply announced policy may or may not be strictly and legally justiciable, the legislation has the operational part, which could be justiciable in the court of law. However, who could normally approach courts for justice may be different in various legislation, there is always scope that violation of legal provision enables the affected party to seek justice from the judiciary. In this context, the efficiency with which the judiciary is actually able to function and give justice to multiple litigants becomes very important. An inefficient judiciary, taking years and decades to decide on cases, could often fails in instilling discipline on the part of the implementing authorities. The attitude of judges to various matters and importance or priority accorded to various cases could be another factor in the availability of speedy justice. As it has happened in many cases, the tradition developed by the judiciary provides scope to powerful people to slow down the judicial process, thus consuming resources and time of Courts and at the same time greatly delaying justice for common people.

Further the manner in which the legislation operationalise policy is important. One of the issues here is, does the legislation provide scope for direct legal actions from people? Or does it give such power to the legally created authority consisting of bureaucrats and others? Since laws are directly connected to policies, which are

product of political process, legislation giving more such authority to the state apparatus invariably reduces people's initiatives for implementation of the law and policies.

Lastly, there is also a great importance, particularly in the field of health, of the policies not formulated and of laws not enacted. For instance, in the health care sector most of the policies are in relation to the government or public provision of health care services, or at least that is how the policies have been interpreted. A cursory reading of health policy literature would show that not much effort has been made to look at the entire health care sector for the formulation of policies. The national priorities in the health care sector are therefore treated as priorities of the public sector alone, for the rest of the components of health care delivery comprising a big proportion of total health care sector; there is no direction or regulation in the policies. Further, much of the health care policies are not followed by legislation. For instance, the creation of village health workers and their abolition was affected through policies, without according any legal status for continuing health-work by those workers. Similar is the case of Male Health Workers in the Primary Health Centre infrastructure. They, unlike their counterparts, the Auxiliary Nurse Midwives, are not legally registered as a part of any professional or paraprofessional cadre, thus condemning them to resort to illegal health care work or inactivity after they leave the job.

Laws and health care sector

The health care service sector in India has come of age. Both in terms of the medical human power and physical size as well as investment and expenditure in health care, this service sector has become vast and vibrant though it is still mal-distributed and the average quality of services not commensurate to what it could achieve.

Vast amount of data collected, especially in last two decades have shown that we no longer acutely suffer from paucity of the medical human power. On the contrary India has now one of the largest medical human power in the world. From one doctor for about 6700 persons at the time of independence we have now one for less than 900 persons, the ratio being even better in the urban area where we have a doctor for less than 400 persons. According to 1981 Census, 41.2% of all and only 27.2% of allopathic doctors were located in the rural areas, and according to an estimation by the author, not more than 14.8% of all registered doctors work in the public sector. A recent study done in a socio-economically average district in Maharashtra found only 8% of all qualified doctors in the public sector employment. Further, 20 to 30 thousand doctors of all systems are trained every year and enter the medical market, chiefly in the private sector.

In 1988 there were 9,831 hospitals and 5,85,889 hospital beds in our country, a 2.8 and 2.2 fold increase respectively as compared to their number in 1974. These numbers are also under-estimations as private hospitals and beds registration in majority of the states is not done properly. Although no hard data on the investment

in the health sector are available (except on the govt. investment), the visible trend towards the setting up of large, hi-tech, corporate and other hospitals and diagnostic centres suggests that a considerable proportion of nation's investment is in the health care sector. This is buttressed by the findings of various studies that health care expenditure in India is very high (anywhere between 6 to 8% of the GNP, almost four fifth of which is private expenditure, only one fifth being financed by the state), as compared to its underdeveloped economy and the prevalence of poverty.

The coming of age of the health care sector and the burgeoning market of medical care need to be examined from the perspective of the social usefulness of the system of health care that has evolved, the role of state (actual and intentional) in regulating the sector in order to achieve social objectives. The health policies and legislation provide base for such an analysis.

The growth of health care sector would make one feel that it would be accompanied by the regulations for achieving social objectives. But as stated earlier, that is not the case. Further, one also finds that the growth is haphazard and chaotic, not articulated within any plan or policy for national level health care system. The plan that was available at the time of independence, the Bhore Committee report, was abandoned in no time, save for some of the terminology and nomenclature. Thus, while the growth of the government health care has remained very slow, the real growth that took place in the private sector has been simply market driven the state only helping in the process. As a consequence, we have a system of numerous multiple providers, several systems of medicine, the big chunk of health care expenditure paid for by the millions of people from their pocket, and the direction of development in one geographic region or field of health having no connection, some time working at cross purpose with the direction in other regions or fields.

In many ways, what we have evolved comes closer to the structure of health care in the US, though we began with a promise to go British way. This also makes it difficult, as indeed it is in the case of the US, to describe our health care as a system, for it may not be able to withstand rigour of analysis to call it so. Despite being so close, or evolving in that direction, in its structure to the US health care, it lacks the degree of state social security support and the market level stringent regulations of the US. Thus, the health care in our country exhibit neither the radical regulatory phenomenon to achieve social objective of equity, redistribution of resources and universal access, nor does it show regulations that go with the health care market. For instance, the health care is perhaps the most heavily regulated industry in the US (Levin, 1980: 1). And this remains true despite the attempts in the Reagan era to dismantle regulations, for the downfall of de-regulations started as fast they began. The heaviest regulations do not mean that the regulations are actually due to keeping in place a universally accessible health care service, as is the case in many Western European countries and in Canada. The heavy load of regulations in the US is for keeping the market in health care healthy, for providing safeguards to consumers, for controlling prices etc. These regulations are more- often-than-not the legislated

regulations, or laws. In addition, the regulations are exercised by courts through the common laws, torts.

Despite such regulations, the US health care is neither universally available, nor the providers are socially accountable, the cost of health care has kept increasing unabated and arguably, the average quality of care is not as high as compared to the potential of scientific and technological base would provide. That has been a reason why in 1970s there has been big demand for reorganising the US health care in the British or Canadian way, in 1980s the neo-liberal demand for de-regulations and in 1990s the Clinton's effort to further reform the system. For both for its sheer quantity on the market and for the heavy load of ineffective regulations make the health care a most talked about issue in the US politics.

Now as compared to the US, in our country, the health care is perhaps the least regulated industry or sector. While the vested interests among the medical elite may still clamour for more "freedom" or agitate against the consumer protection act, it is difficult to make out a credible case for deregulation in the health care field. That is the reason why, both the neo-liberals as well as radical have one thing common in their approach, that is, the health care need some stringent regulations. They differ, however, in the kind of regulations, which are needed in the health care sector.

Our approach:

Our survey of health care legislation and the disinterest shown by the state in implementing available regulations, show that in the health care sector the to apply the government policy of deregulation has no meaning. The need for regulations is very great. And this need encompasses from the simple market related areas like creating transparency in the market place transaction of health care to the areas of affecting equity.

Our approach is two fold: our survey of health care legislation show that in our country there does not exist laws for making the health care universally accessible. The government policy of making provision for health care is not backed up by a comprehensive law that makes basic health care a right of people. On the other hand, there are laws, inadequate and improperly implemented, for regulating health care providers and the health care market. Thus, for market reformers there is already something available in law to build upon. We have therefore, done a review of such legislation, and compared them with similar legislation in the developed world to bring out the consequences in implementing as well as not implementing such laws.

Secondly, we have analysed legal issues from the standpoint of making health care universally accessible to all people and for providing various health care rights to people. We strongly believe that this perspective should guide us in both policy formulations as well as in its operationalisation through legislation.

Objectives of the study:

The overall objective: To document, collate, critically examine, and to study legislation and regulations applicable to the individuals and institutions involved in the delivery of health care services.

The specific objectives:

(1) To collate the existing legislation and regulations applicable to individuals and institutions involved in the delivery of health care services in India.

(2) To study gaps, inadequacies in the existing legislation and regulations and to make recommendations for changes and also, to identify areas where new legislation/regulation are needed, with a view to increasing efficiency, improve quality and access of services and to empower people.

(3) To compare existing legislative and regulatory mechanism in India with that in a developed country.

Methodology:

As explained in the report, reviewing legislation specifically applicable to individuals and institutions providing health care was not an easy task. Despite the Bhore Committee recommendations half a century back to bring together all laws in one book and to enact a comprehensive public health act, we found it difficult to lay our hands on all laws of the central and state governments.

The government health ministry and law and judiciary department officials were not very useful. For instance, five years back, in a case of medical malpractice, a relative of deceased victim approached the Municipal Corporation and the Health Ministry to find out the law regulating hospitals in the city of Mumbai. She was told that no such law existed in the state of Maharashtra. It was only when, with the help of some friends, she could locate the Bombay Nursing Homes Registration Act, enacted way back in 1949, that they accepted existence of some regulations on the hospitals. Of course this amnesia was motivated by lack of any will to properly implement the legislation.

Yet we decided to send a questionnaire to all health secretaries and secretaries of the law and judiciary ministries of all states to elicit their response on the existence of laws for health care provider. The questionnaire requested information on various topics, such as:

(1) Medical Council for various systems of medicine, the constitution of such medical councils, the last elections for the councils held etc.

(2) The legal requirements for establishing and carrying on medical practice.

(3) The legal actions taken against unqualified and unregistered medical practitioners.

(4) Constitution of the state and district consumer councils and their functioning.

(5) The legal requirements for establishing and carrying on a nursing home or hospital.

(6) The minimum physical standards prescribed for the hospitals and nursing homes and their inspections.

(7) The legal requirements for establishing and carrying on pathological laboratories blood banks, radiology units, private drug stores etc. And the minimum prescribed standards and inspections of the same.

This questionnaire was sent twice by registered post. In addition in a meeting where most of the health secretaries of the states were present, it was personally handed over to them and a promise was received that the response will be sent.

However, at the end the responses arrived only from three states, namely, Karnataka, Andhra Pradesh and Meghalaya. The rest of the states even did not separately acknowledge the receipt of questionnaire. In the states from which the responses were received, the questionnaire was filled up by an official from the directorate of health services and not by the ministry.

The responses from the three states were nearly identical, but all of them had not replied to all questions. For instance, Karnataka did not say when the last elections for medical council took place, in Andhra Pradesh, the elections for allopathic council took place 1988, to the Andhra board in 1971 and to the board of Indian medicine in 1982, and Meghalaya which enacted a law for it in 1987, no elections have taken place. At no place any specific permission for establishing and carrying on medical practice is mentioned. Andhra Pradesh and Karnataka do not demand permission for establishing nursing home, but Meghalaya has passed an act for the same in 1993 but it does not stipulate any minimum physical standards. Of course none of them mentioned the practice of regular inspection of nursing homes. Further, for establishment and carrying on with laboratories etc, again no legislation exist, save of the ones for the drug stores.

Thus, our questionnaire did not generate adequate response from the authorities. This only confirmed our point in the review of legislation that not many laws at the state level are in existence for regulating the health care providers.

Another is for data collection chosen by us was the study of functioning of medical councils. Although we did not get empirical information from this study, our encounter with their officials provided lots of insight into the functioning of the

councils. The methodology and findings of this study are described in the chapter on functioning of councils.

The major component of this study is of course review of legislation as they exist. As per the objectives laid down for the study, the legislation was analytically dissected with the help of expert lawyers and their provisions were examined. They were also compared with the similar provisions existing in some advanced countries. Similarly, in order to understand constitutional and legal right to health care, a review of various committee reports, the provisions made or not made the government were examined. This was compared with the legal right to health care in other countries.

2. RIGHT TO HEALTH CARE
Entitlement and Law

Historical

In the field of Indian medical history, historians have paid more attention to the Indian systems of medicine, their scientific and technological aspects and their relationship with the Indian philosophies. Although such writing on Indian medicine have provided some very useful insight into the way medicine was practised, a systematic exploration of medical care provision and the rules and legislation on it, is yet to be undertaken.

The earliest Indian civilisation known to us is the Indus Urban Culture of 3000 to 2000 BC. The archaeological evidence show that these cities had well-planned drainage system, almost all houses had bathrooms, many houses had latrines and most houses had wells for water supply. The renowned medical historian Henry Sigerist (1987: 142-3) believed that public health facilities of Mohenjo Daro were superior to those of any other community of the ancient Orient. Unfortunately, we do not have much evidence on the way these societies were governed and the kind of entitlements provided by the state or the community to the individuals and the households. However, the extent of development of public health system points to some kind of state or community planning which enabled the citizens to get entitlement to hygienic public health arrangements.

The written evidence of the state's involvement and the regulatory function is available from the Kautilya's *Arthashastra*. Kautilya considered famine as a bigger calamity than pestilence and epidemics, as the remedies can be found for the diseases. He believed that the king should order the physicians to use medicine to counter epidemics (Rangarajan, 1992: 130-1). The *Arthashastra* also makes mandatory for the doctor to report to the state whenever the doctor is called to a house to treat a severely wounded person. This also applied to treating the one suffering from unwholesome food or drink. Such immediate reporting was mandatory in order not to get accused by the crime committed by such patients. If the doctor failed to provide information to the state, he would be charged with the same offence committed by such patient. (Ibid: 360)

For not providing proper information to patient, for committing mistake in and for being negligent in treatment, the *Arthashastra* provides for punishment, fine, for the doctor and compensation for victims (Ibid: 251, Kangle, 1972: 258). *Arthashastra* is replete with prescriptions of so-called medieval punishments, including strong

recommendations for using torture for getting information or confession, and even using it for punishment. While in the field of ancient medical ethics and laws, the code of Hammurabi prescribing "eye-for-eye" punishment for the doctor injuring patient in the treatment is well known, the punishments prescribed and practised in Kautilya's time are less known and talked about. *Arthashastra* is a very definitive and practical book. Its identification of each point of state-craft, economic management, infringements and the specific and detailed punishments partly read like a code. It has received less attention perhaps because its writing on the medical practitioners and their duties are part of crisis management, combating recurring famines and epidemics, and also a part of "consumer" protection in general. When we are still trying to properly codify and implement doctor's duty of giving proper information to the patien, the *Arthashastra* had made mandatory for the doctor to give prior information about treatment involving life and having consequence of causing injury. A failure to give such information invited harsher punishment if the patient died or suffered injury. It prescribes the following punishment for "negligence" in treatment:

Doctor not giving prior information about treatment involving danger to life with the consequence of	Punishment prescribed
*Physical deformity or damage to vital organ	Same punishment as causing similar physical injury
*Death of patient	Lowest level standard penalty (primarily fine)
*Death due to wrong treatment	Middle level standard penalty (primarily fine but high amount)

(Source; Rangarajan, 1992: 251,112)

Thus, *Arthashastra* equated injury due to treatment given without explaining consequences to patient with the similar injury caused in any criminal offence. The death due to wrong treatment invited more penalty than the death as a consequence of correct treatment. Lastly, compensating injury with money, a practice in the present day medical malpractice litigation was known and practised during Kautilya's time. This is indeed an advance over the Hammurabi type "eye-for- eye" justice system for medical negligence and draws attention to the advancements made by the ancient justice system in India as compared to other countries of that time.

This detailed description shows that state-craft of that time put certain obligations and regulations on the work of doctors.

During the Buddha period, there are evidences to show that the state supported University of Taxila, which among other things, provided medical education to students. Bhikshu Atreya taught there and Jivaka was a product of this Univresity (Mukhopadhyay, 1923: 92 & 94). During the Ashoka period (270 BC) the state showed interest in the public works and the provision of medical care. Ashoka founded hospitals all over his empire with medical attendance at state expense (Kosambi, 1970: 160, Kosambi, 1975). The state also undertook planting of medicinal herbs, planting of trees and supply of potable water from wells along the

highways. Ashoka also assisted in the establishment of medical centres in the neighbouring countries (Thapar, 1973). Further evidence on the state's interest in medicine is available from the Chinese pilgrim Hsiuan-tsang who studied at the monastic University of Nalanda, which also provided medical education (7th Century AD), The Nalanda University was supported by the revenue collected from more than 100 villages given to it by the King (Kosambi, 1970: 176-7, Thapar, 1966:154).

The known text books of *Ayurvedic* medicine took many centuries in getting fully compiled. In this process (which also required meeting of scholars and practitioners) the state extended support from time to time. It is suggested that these texts emerged in real fixed form in the first five hundred years AD (Jeffery, 1988: 43). Around the 12th century AD the Muslims brought their own physicians with them and thereby introduced a new system of medicine knows as *Unani*. Jeffery (Ibid: 46) has suggested that in this period, "successful practitioners were those who served successful rulers and, either through regular service or because of some special healing act were granted an area of land. These grants may have been supposed to fund specifically medical activities -a dispensary or a small medical school- or they may have been grants to the man and his heirs, even if they ceased practicing medicine." Reddy (1941) has documented medical relief in Medieval South India and noted that both state and religious institutions often subsidised and supported medical care.

There hasn't been serious and sustained attempt in our country to document the system of self-regulation of physicians and the state laws to protect people from the misdeeds of physicians in these periods. Chattopadhyay (1977:21) discusses ethics in the *Charaaka-Samhita*, while Sinha (1983: 266) has argued that "the *Ayurvedic* physicians of ancient India had a well defined medical ethics". Similarly, Pandya (1995) has summarised various aspects of medical ethics prescribed by Charaaka, Susruta and other Indian physicians. On the other hand, there is almost no sustained evidence on state's special or direct interest in regulating medical practice or the medical practitioners.

However, the situation started changing from the British period in the modern history. The colonial power brought with it its own physicians and barber surgeons. In the mid-19th century, as the medicine got recognised in England, it slowly started having its impact in India, too. Further, the public health campaigns, the increasing intervention of the state in the provision and regulation of health care, establishment of hospitals and above-all the development of scientific medicine gradually led to the establishment of what we know as the organised health care service systems all over Western Europe. However, the colonial power was not interested in making the necessary investment in developing such well organised health care and public health campaigns for its subjects. After 1857, according to Radhika Ramasubban (1982, also 1985), the main factors which shaped colonial health policy in India were its concern for the troops and the European civil population. The genuine public health measures remained confined to the well planned cantonment areas housing British people. She has also documented that for the general population the sanitary measures were

started in ad hoc fashion for pilgrim centres but the realisation that they would be very expensive made the colonial government shelve the programme under various pretexts. She also contends that as the era of sanitary reform was superseded by the professionalisation of medicine in England, the colonial government shifted the focus from the sanitary reforms to public health research in India.

Nevertheless, the colonial government could not confine its support to health care only in its well organised cantonments. For various reasons, it had to make some provision of health care for the masses, too. For instance, in a study by Muraleedharan (1987) of the "Rural Health Care in Madras Presidency: 1919-39", he finds that the colonial state had established dispensaries and hospitals for the people, more in the urban areas but less in the rural areas. In 1924 it introduced a scheme called Subsidised Rural Medical Relief Scheme (SRMRS) which was intended to subsidise private practitioners who agreed to settle down in villages. Such private practitioners were not considered government servants, were required to settle down in the villages specified by the local boards and were asked to treat the "necessitous poor" free of charge. However, this scheme was only partially implemented. Despite such inadequacies in implementation, it was in this period that the establishment of a nation-wide formal and organised health care system was started.

This process of establishment of health care system also necessitated creation of legislative framework for it and for the practitioners of medicine. In its earlier period of rule, the physicians and surgeons brought by the East India Company and after 1857 by the British government, needed some discipline and regulations. Lt. Colonel D.G. Crawford's "A History of Indian Medical Service, 1600-1913" narrates several instances of in-discipline, insubordination, malpractice etc by such doctors and the punishment (including deportation) meted out to them. It also narrates the regulations devised by the East India Company for the hospitals established by it.

After the enactment of the law establishing General Medical Council in 1857 in England, the British doctors employed in India were registered with the GMC and came under its disciplinary regulation. As the number of doctors qualified in Indian medical colleges increased, creation of laws for them became necessary. Similar development took place for the nursing profession. A brief history of the legislation enacted for health care professionals is given in the subsequent chapters.

Post independence developments

The independence in 1947 inagurated a new phase of development of organised health care services creating more entitlement for the people. Along with that, the state also embarked on enactment of new laws, modification of the colonial laws and the judiciary developed case laws to consolidate people's entitlement of health care and to an extent, the rights. This development took place on the basis of numerous recommendations made by various committees. In this section we will briefly review reports of some of the committees while in subsequent sections we will examine in detail provisions of laws enacted.

Committees on Health Services and their recommendations on health laws:

At the time of independence, and the first few years of planning, the task confronting the country was to create physical and institutional infrastructure for the rapid development or modernisation of India.

BHORE COMMITTEE (1946):

The Bhore Committee Report while emphasising the need for rapid socio-economic development for the success of its health care plan, did not want the medical practice to remain confined to its traditional role of curative care and simply wait for the socio-economic development to improve the health status of the people. It made comprehensive recommendation in order to orient the medical practice to actively aid in the improvement of health status. Thus, it suggested that "preventive and curative work should be dovetailed into each other in order to produce the maximum results" (Vol. II: 24). The National Planning Committee Report on National Health (Col. Sokhey Committee, 1948), too, emphasised on the integration of curative and preventive health care functions. This position of Bhore Committee was not based on any abstract idealism but on a very practical concern for the interests of majority of people and for the maximum utilisation of the professional efficiency of the medical personnel. It stated that "a combination of curative and preventive health work is in the best interest of the community and of the professional efficiency of the medical staff employed. In fact the two functions cannot be separated without detriment to the health of the community" (Vol. H: 40).

The Bhore Committee functioned in the post war situation of global radicalisation and in India, the success in making the colonial government in deciding to leave, had created an atmosphere of high level of concern for making the basic necessities available to people. The post war Europe was undergoing massive change and with the expansion of the welfare state, the health care services were getting reorganised on the principle of providing access to all people. To this was added the experience of Soviet Union which had shown considerable success in making health care available to people. Thus, the Bhore Committee produced a report which is the only and truly comprehensive document produced by any committee on health so far, whether appointed by the government or by other organisations.

Three important characteristics of the report are:

(1) The holistic and comprehensive way of analysing the situation. Thus it deals with the health sector in its entirety, bringing in its framework all components, from the community level service to the tertiary care; curative, preventive and promotive health care; the social and economic changes necessary for achieving better health status for the people; and the health care services available in the govenment, private and voluntary sectors. Such a holistic analytical approach is conspicuous by its absence in the reports of most of the subsequent committees.

(2) It formulated a national level time bound plan for the development of comprehensive health service with the central concern of making it accessible to the masses of people. While the report suggests interim measures (e.g. use of less qualified health workers, the community based informal providers etc), it is very clear in calling them temporary measures necessitated by the situation of underdevelopment. For its plan endeavoured to overcome the underdevelopment, not to adapt to it. For its aim was clearly for making available organised health care system supported by the state so that people don't have to suffer from the vagaries of the market. Given the greater influence on it of the development of health care in Europe and the USSR, its understanding of comprehensive health care was accorded a fundamental importance within the state supported health care system in the rural areas.

(3) It was thorough in its recommendations. Almost all areas, including many of those not falling directly within the purview of health ministry and administration, but are important for improving health status of the people, were identified for recommendation. This is also reflected in its greater dealing on the legislative and legal framework needed for the developing health care services in India.

Legislation and Regulation: Legislation, not mere pronouncement and even policy statements which are often tardily implemented and the implementation is largely left to the desire of the Ministry and administration, are important in democratic political structure for they create legal framework in which there is some scope from below to seek remedial action. The Bhore Committee refrained from doing a detailed survey of health legislation required for implementing its plan, under the plea that "legislation and administration constitute parallel lines of state activity, which continuously act and react on each other, with the result that the implementation of our programme is bound to produce, as it proceeds, the need for legal powers in various directions, which can hardly be anticipated at this stage" (Vol. II: 502). Understandably a full review was difficult, but in its otherwise detailed outline for legislation and details on legal regulations for the health care professionals, one doesn't find elements of long range recommendation for legislation to legalise its desired goal of achieving a National Health Services for India by implementing its plan. While in the initial pages of its voluminous recommendations it uses the ideal of achieving what the proposed national health service in UK promised, a service "designed to provide for every one, who wishes to use it, a full range of health care" (Vol. II: 3), it falls short in its outline of immediate and future legislation required (Vol. II: 502-507) to even touch upon the need for a legislation like the National Health Service Act, 1948 of the UK. The White Papers and a bill for the NHS were introduced in the British parliament in 1944 and the NHS Act was passed in 1946, the year in which the Bhore Committee submitted its report. Its recommendation of a comprehensive social policy without recommending a comprehensive social legislation, appears very inconsistent with other pronouncements made and the ideal goals set in the report.

Nevertheless, in respect to other specific needs of its proposed plan, the Bhore Committee showed acute awareness about creating legislation and legal framework.

It formulated its proposals for legislation under four heads:

(1) Those which were intended to assist in the formulation and execution of a national health policy based on the largest possible agreement between the Central and Provincial Governments and to promote the coordination of central and provincial health activities. The recommendations made in this field are not fully worked out, but they do give general outline for two types of legislation:

a. The establishment of a statutory Central Board of Health with the Central Minister of Health as the chairperson and Provincial Ministers of Health as members. This board was envisaged as a forum for discussion and formulation of a health policy based on the agreement generated. It was also envisaged as a forum for avoiding friction in the implementation of the policies formulated. Although we are not sure whether there is a specific legislation for the establishment of such a Board, one knows of the existence of the Central Council of Health. However, the Bhore Committee envisaged the strength of this committee in the implementation of its plan. As the plan investment in the health slackened, the power of the centre was bound to decline. In the recent years the decline of its importance has become very evident as the centre's own contribution in financing health is no longer as great as it used to be. Further, the accentuation of disparities among states in the health field made the interest of various states divergent, making it difficult for the centre to establish authority for having better uniformity in the health care provision across the country.

b. Empowerment of the centre to intervene, without delay and effectively, in provincial health administration in circumstances in which dereliction of duty by a provincial government jeopardises the health not only of those under its charge but also those living in adjoining areas outside its jurisdiction. The centre seems to have such powers, but specific legislation on this subject is not known to us. Like in most other matters, in the field of health, the parameters for such central intervention are not properly worked out. Thus, the allegations of discriminatory intervention have largely "politicised" this important function of the central government.

(2) Those which were designed to improve health administration in the provinces, particularly standards of such administration in local areas. The following outline of specific recommendations were made:

a. The creation district health boards.
b. Empowerment of the provincial (state) health ministry to enforce compliance by the district health boards with its policy.
c. (i) provincialisation of classes of health workers, (ii) power to public health department for implementation of public health by the local health boards in concurrence of the state government.

d. Provincialisation of those classes of health workers falling outside the scheme outlined by the Bhore Committee.

Evidently, most of the recommendations related to district and state health administration have been incoporated in the present day health administration.

(3) Those which are required for conferring special powers on health authorities to enable them to carry out their duties more effectively than they are able to do at present. This was an important recommendation for streamlining the work on public health. It also intended to give powers to the central government for supplementing efforts made by the state government. While outlining this principle, the Committee identified two areas for specific recommendations, other areas were to be identified by the government in the course of time.

a. Control of infectious diseases: The report discusses malaria (for anti-mosquito measures) and small pox (for vaccination and revaccination). While showing great concern for the measures required to prevent and combat inter-provincial spread of diseases, it made recommendation for giving the central government some legal powers in line of those existing at that time in the US. This was to ensure joint action of the central and state governments to meet the situation created by the inter-provincial spread of diseases. This aspect is well enshrined in the practices followed by our central and state governments. However, the Committee's recommendation in this regard to enact a consolidated Public Health Act has remained on paper, although the subsequent committee (Mudaliar Committee) did carry out an exercise to formulate such an act.

The Public Health Acts were recommended for the central as well as state governments. This recommendation was made for three purposes: (1) to bring together existing legal provisions relating to health, which are scattered over various enactment, (2) to modify those sections of the law which require change in the interest of promoting efficient administration, and (3) to incorporate new provisions which will be necessary for the health programmes recommended by the Bhore Committee.

However, keeping with the government policy of doing as little legislation in the field of health as possible, such consolidated act was never adopted. While such a policy provided more flexibility at the level of policy making and affecting administrative and other changes for the implementation, it also created a situation of frequent changes resulting in chaos. The change in legislation need time for wider parliamentary and other public debates. It also means that a policy change is not carried out as a reflex action to meet a situation but is an outcome of political and public discussion. In the absence of legislation, the involvement of people in health care debate declined, and policy changes started becoming administrative fiats. This is perhaps one of the reasons why one finds more concern with the bureaucracy and administration than with the political process in the debates on health policy making in India. The political process is often

reduced to the so called political will, a concept largely left undefined, sometimes exhibiting an authoritarian overtone. The point is that the creation of political will is a political process, and in parliamentary democracy the serious or somewhat serious political process is ensured even in the less interesting field of health when it is directly related to making legislation or amending them. Thus, in the absence of having a consolidated and specifically drafted health act, the policy making process has become highly mystified, a prerogative of experts and bureaucrats rather than that of people and their representatives.

b. Control of purity and quality of community's food supply: This recommendation related to empowering the central government for ensuring quality of food supply across the states, i.e. inter-provincial trade in food items.

(4) Those which were intended to give statutory sanction to certain proposals, e.g. the All India Medical Institute, certain aspects of which involved departures from the then existing administrative procedure.

One more important recommendation made by the Bhore Committee was very simple and yet has remained unimplemented. This related to the confusion in the field of health legislation. As it is now, so it was then, that aspects of health legislation are scattered in various laws and regulation. This does not provide a picture of scope and purpose of health legislation to the people and even to experts. So it was recommended that the government should undertake to bring together in a single publication all the existing laws relating to health, both central and provincial. The very fact that such a simple task was never undertaken only shows the low importance given to legislation in translating policies in a definitive formal and legal commitment.

It must be stated here that the primary objective of the Bhore Committee was to create a legislative framework for its plan. It dealt with the issues in health care outside the scope of plan only when absolutely essential. Further, it felt that the financing and implementing its plan was such a modest endeavour that it did not think in terms of its possible derailment by slow and/or diluted implementation. The dominant understanding of its time that the state must intervene, and intervene with a definite resoluteness is so strong in its report that it took it for granted that the public sector in health care would not only be playing a leadership role but would also be a dominant provider of health care services. Thus, it gave less importance to integrating the role of private providers in the health legislation formulated or recommended by it.

Nevertheless, on certain aspects, its recommendations cut across the boundary of public and private sectors in health care services. There are two areas in which this is evident: one related to drugs and pharmaceuticals and another to the health care providers.

Drugs and pharmaceuticals: Its recommendations were on three major points: (1)

for ensuring adequate production of drugs and pharmaceuticals and their proper distribution, (2) for instituting price controls to make them available to all those who need them, and (3) for maintenance of adequate standards in production and storage and for the quality control.

While for the first issue, it advocated production in the public as well as private sectors, for the second issue it did not make any specific recommendations. However, the post independence developments show that the production have been carried on in the public as well as the private sectors, the former starting strongly in the production of bulk drugs only to slow down later on and the latter concentrating on the profit making production of formulations. The drug price control was systematised in the 1960s, and again following the Hathi Committee recommendation in the 1970s, only to give way to more liberal approach to drug prices in the 1980s and early 1990s.

For the third, it recommended a licensing system and adoption of the Drugs Act, 1940 for the country with suitable modifications. This was acted upon by enactment of the Drugs and Cosmetics Act in the 1950s.

Health care providers: The Bhore Committee deliberated in great detail over the legislation for the health care providers. There also existed some amount of difference within the committee on the subject. The majority members of the committee were guided by the provisions available in the Medical and Nursing Acts of the UK. Thus, they are very clear that some strict regulations over the health care professionals are necessary in the good interests of the society. Some of their specific recommendations were as follows:

Doctors: The committee justified the regulation by staling that, "It is part of the democratic conception that the individual citizen has the absolute right to take his ailments for treatment to anybody he chooses, but it is also part of the individual citizen's right that he should have an exact comprehension of the pretensions to competence of the individual he employs." (Vol. II: 458). Further, "We consider, ..., that legislation restricting the activities of persons not qualified in modern scientific medicine is desirable and overdue." (Vol. II: 460).

Thus, the committee recommended establishment of legalised self regulatory medical council(s), maintaining provincial and national registers of doctors, setting standards for medical education, examination etc. broadly in the same framework as the General Medical Council of the UK. It also proposed to restrict work of the non-qualified doctors. While the majority of the committee recommended that decision at the national level regarding the regulation of the non-modem or indigenous systems of medicine should be made by "the leading authorities of the systems concerned", a minority members wanted a definitive recommendation that the indigenous systems should also be brought under the regulation, in the way it was done under the Bombay Medical Practitioners (BMP) Act, 1938. The Bhore committee, however, while making its majority recommendation also suggested to the provincial governments that they would profit by following the government of Bombay enacting a legislation

in line with the BMP Act, 1938. The government has, in the implementation of the recommendation, taken a middle course. That is, created three medical councils with somewhat similar regulations on all systems of medicine and placed them under the control of the leadership of each system. The medical pluralism was thus formalised, codified.

Dentists: The committee noted that the profession of dentist was completely unorganised. The only legislation existing at that time on the subject was Bengal Dentists Act which (1) regulated dentists' education and (2) introduced registration of qualified dentists. However, this act did not make (1) the registration of qualified dental practitioners compulsory and (2) did not restrict the work of non-qualified dentists.

The committee recommended enactment of laws in order to create central and provincial dental councils. As we would see later, the central council for the dental profession has been created by law but no provincial councils established.

Other health care professionals: In last one and half century, other health care workers such as nurses, pharmacists, physiotherapists etc have emerged as the professionals in their own right. While we have discussed elsewhere the historical emergence of nursing as an autonomous branch of healing profession (lyer, Jesani, 1996), the pharmacists emerged as a separate strata of professionals from the erstwhile apothecaries in England. It is interesting to note that these various branches historically represent a division of labour within the healing profession. The doctors originally combined works of nursing, pharmacist, physiotherapists etc. It is the increasing complexity of medicine, which has forced the medical profession to reluctantly give away a part of its original work to other health workers. These health workers have emerged as the professionals in their own right in their respective fields. However, in the process, the doctors have striven for its domination over the other professionals and got it. One area where this domination is seen clearly is in the councils of these health workers. The Bhore committee recommendations confirmed to this arrangement.

Nursing: Two very important observations were made. Firstly, it recognised the demand of the nursing profession for establishing an All India Nursing Council for coordinating activities of the provincial councils (then 10 in existence), for laying down minimum educational standards and to safeguard their maintenance, etc. It recommended and gave composition of the Central Nursing Council. Secondly it commented upon the composition of some of the provincial nursing councils. This was based on the premise that a Council designed to regulate the training and practice of nursing profession should consist primarily of members of the profession it designs to regulate. However, in the majority of the provincial councils of that time, trained nurses, midwives and health visitors were in minority and in some they were not included at all. This issue is valid even at present in the composition and president-ship of many state nursing councils.

The composition of the Central Nursing Council advocated by the Bhore Committee included 23 members of the nursing profession, 12 members of the medical profession (exclusive of the president) and representation to some women involved in the advancement of women and education. For the initial few years it advocated the president-ship to the Director General of Indian Medical Service, but later it wanted the president to be elected from the members themselves.

It is interesting to note that, not only in India, but the world over, the nursing is treated as an occupation not only subsidiary to the medicine, but the doctors also exercise a considerable direct control over it. At formal and legal level, this control of the nursing by medical profession is expressed in having a highly significant, often dominant representation of doctors in the composition of the nursing councils. Although medicine and nursing are now inseparable and indispensable parts of the healing profession, the reverse of having some representation of nurses on the medical councils is always and everywhere conspicuous by its absence.

Pharmaceutical Profession: For the pharmacists, it recommended establishment by law an All India Pharmaceutical Council and the Provincial Pharmaceutical Councils. Here too, representation for doctors is recommended.

In general, there is another conspicuous aspect of the composition of the Councils of health professionals other than the medical professionals. While for the medical professionals a section of members are to be elected by ballot from the registered practitioners, no such provision was advocated for the councils of other health care professionals.

Differences within Bhore Committee: Lastly, we note a difference of opinion that existed in the Bhore Committee on the frame-work of self-regulation of health care professionals adopted by the committee. One member gave a strong dissenting note on the subject and it has some policy level implications. He asserted that, "When the greatest need of the country is to multiply as fast as we can the personnel necessary for the medical service of the community, including doctors, nurses, midwives and the dentists, I am not in favour of handing over the final power and responsibility of laying down standards of knowledge and experience for entry into these professions and the standards of examinations to the autonomous organisations of these different professions as is suggested by the majority of the committee. Taking human nature into consideration there is some risk of these organisations using their power, in the interest of their particular professions for unnecessarily restricting the entry of fresh entrants into the profession. (.....). I, therefore, suggest that under the present circumstances when the responsibility for the provision of a sufficient number of the personnel for the medical services is on the government, the final power and responsibility for giving entry into these professions should be with the government and the power of these autonomous organisations should only be advisory and recommendatory".

The policy level implications for this dissenting note might be very appealing. There have been instances in 1960s and 1970s, when the government tried to introduce shorter training for basic doctors required for the health work, the medical profession blocked such moves using its collective might, including its clouts in the medical councils. However, much of the battle against such move was fought outside the councils, in the political arena where the government could not show sufficient political preparedness to resist the pressure of the profession. Besides, the legislation enacted for the professionals fall mid-way between the self-regulation propounded by the majority and the government control arguments of the lone minority. As we have shown later on, the medical councils are neither fully autonomous nor are they fully under government control. The hold of the ex-officio government medical bureaucrats and the members nominated by the government is considerable. Further, the councils have in actual reality only the recommendatory powers on medical education. And lastly, the only objective of the Bhore committee realised fully by now is on the production of doctors of all systems of medicine put together. Given the expanding market of health care, the fear that the monopolistic power with the councils would act as barrier to entry has proved to be unfounded. On the contrary, the governments have applied political pressure to bend councils for giving recognition to a large number of private medical colleges. Thus, the situation has turned out to be more complex than was anticipated in the dissenting note by the lone minority member.

MUDALIAR COMMITTEE (1961)

After Bhore Committee, the Mudaliar Committee produced a well-researched and comprehensive report. Since one of its objectives was to follow-up recommendations of the Bhore Committee and developments in health care a decade after independence, its scope was vast and it made detailed recommendations. We will not go into merits of its major recommendations, but concentrate on what it said on the legislation.

Public Health Act: The Mudaliar Committee followed up the recommendation of the Bhore Committee for formulating a comprehensive and consolidated public health act in all sincerity It formulated a draft of Model Public Health Act, a document containing 57 chapters and 300 typed pages. This draft model act is less known and even less accessible. However, it appears to be a very comprehensive document. Although many of its recommendations are apparent in the administrative set up of the directorates of health services, many others are not acted upon at all. It is also surprising that all subsequent committees, whose recommendations introduced many frequent changes in the health care set up, have also failed to take their recommendations to logical conclusion by enriching this model draft of the act.

It claimed that the draft act, for the first time, aims at legislating the social machinery to provide for the people a reasonable standard of health care in the curative, preventive, promotive and rehabilitative fields. "The Draft Act aims at being the

legislative counterpart to implement fully the recommendations made in the Bhore Committee and Environmental Hygiene Committee reports and has envisaged a comprehensive and integrated Health Services covering all the essential fields." (Vol. II: 271-2).

The draft act tried not only to legislate for provision of medical relief, but also tried to establish standards for such service, a task inadequately addressed to in the subsequent reports and studies. It also provided responsibilities and powers to the local authorities. The state authorities were made to assist the local authorities in provision of finances and technical know-how. However, it also gave powers to the state authorities to supersede local authorities in certain situations. It proposed that one third of the income of municipal authorities and one fifth income of non municipal local authorities to be earmarked for public health purposes.

Interestingly, the draft act did not confine itself to the government and local health facilities. It included in the purview of legislation the private nursing homes and sanitoria. This was to be done by (1) licensing and (2) by maintenance of their standards. Thus, it seems to have made an attempt to rationalise the public/private mix of health care services under appropriate regulation and standards.

Another remarkable feature of the draft act was that it provided an outline of standards and other particulars for incorporation in rules and by-laws.

This was the first and perhaps the only attempt at formulating a comprehensive legislation covering the government, local bodies and private health care services.

OTHER COMMITTEES AND LEGISLATION

It is really unfortunate that most of the committees appointed after the Mudaliar Committee report was released paid scanty attention to legislating, their recommendations. This is seen in reports of the Committees such as Mukherjee Committee (1966) on basis health services, Ajit Prasad Jain Committee (1968) on hospitals, Srivastava Committee and so on.

Firstly, all such committees were given terms of reference, which were very specific and narrow. Thus, they did not carry out comprehensive survey of health care in all sectors.

Secondly, all such committees, even in the area of their inquiry, did not take a holistic view. For example, the Jain committee did a commendable job in devising hospital standards, but they restricted themselves only to the public sector hospitals and did not even make any attempt to formulate standards for hospitals and nursing homes in the private sector. It even did not say that the standards recommended by it should be applied uniformly to all hospitals, irrespective of they being in public, private or NGO sector. This exclusive preoccupation with the public sector health facility, without systematically relating it to the private facilities and streamlining both of

them under the single system standards to be met, pervade reports of almost all subsequent committees.

Thirdly, all of them assumed that since the recommendations were only for the public sector facilities, an administrative measure to implement them was sufficient. None of them made concrete recommendation to the Central Council of Health to legislate their specific recommendations in order to have a permanent impact and a compulsion on the part of the state. As a result, the implementation was always tardy, at the will or absence of will, of the state. The citizen has no way to use any legislated policy to pressurise the government through democratic legal action

Fourthly, all committees ignored the need for people's initiative for the implementation of the recommendations. No recommendations have ever been made to give concrete rights to citizens, save for the exhortations for community participation, advisory committees of elected panchayati or other representative etc. All of them uniformly failed in defining the minimum quantity of health care that the health care institutions of government were obliged to deliver, and none talked in terms of giving people legal right to have such minimum quantity of health care.

Lastly, in many recommendations the legal implications were ignored in favour of the supposed immediate need for improving the situation. For instance, the use of health workers (uni-purpose, multi-purpose, Village Health Guides) in providing primary curative preventive and promotive health care were recommended and implemented without creating legislative framework. Thus they are still there without having any legal *locus standi*. Except the Auxiliary Nurses who are provided registration with the nursing councils, the rest of such paramedical workers have no such independent legal existence except being the employees of the state. While the state has not seriously suffered due the consumer apathy and difficult access to legal recourse, it is an open question as to the legality of work carried out by them without any immediate supervision by the professional staff at the sub-centres. The acute crisis in this field is faced by, NGOs who employ such staff and do not have resources and partial immunity that such health workers enjoy in the government sector.

ICMR/ICSSR COMMITTEE, 1981

This committee was not appointed by the government, and thus had lots of flexibility in its objectives and function. As an exception, it did attempt a comprehensive review of the health and health care situation. It also recommended a new plan for the farther development of health care services in India.

However, it still confined its recommendations only to the government sector, did not envisage any concrete plan to bring private sector in the purview of planning and above all did not make any specific recommendation for legislation(s) to put firmly in place its new plan. Not only that, its review completely missed out a review of health legislation.

There are two neglected fields, the practitioners of other systems of medicine and nursing professionals, where one would expect strong recommendations from the committees appointed to review those fields. Our survey of their reports produced only a mixed result.

NON-ALLOPATHIC SYSTEMS OF MEDICINE:

The report (1989) of the working group appointed by the Planning Commission, on ISM and Homeopathy for the Eighth Five Year Plan, is very disappointing. It is well known that a large proportion of practitioners of these system, practice modern medicine and the medical councils of those systems are in worse shape than those for the modern medicine. The report mentions that the educational standards in the Indian Systems of Medicine (ISM) and homeopathy colleges are nowhere nearer the minimum standards laid down by the Central Council of Indian Medicine and Central Council of Homeopathy. But the report fails to go into the details of why scanty attention was being paid by the central governments, state governments and above all by the central and state councils of the respective systems for enforcing such standards.

The practitioners of medical systems which comprise almost 60% of the registered medical practitioners in India, are thus not in actual reality brought under the strict regulatory framework despite the existence of laws. This again shows that the expanding market in medical care has not allowed the monopolistic powers of the profession to be used for barrier to entry. The state has, on the other hand, disregarded standards of education and put the people at risk. Thus, there is a collective failure of the profession and the state to uphold the spirit of safeguarding people's interests.

NURSING PROFESSION:

The nursing profession, on the other hand, has shown much more awareness for a strict regulatory legislation. Three objective reasons for this could be offered.

First, the legislation for nursing is very inadequate to start with. As a consequence, the nurses face great competition from the unqualified workers.

Second, the number of nursing human power available in the country is far low, one nurse for two doctors instead of three nurses for one doctor.

And thirdly, the nurses, unlike doctors, can hardly do much independent nursing practice. Their dependence on the medical institution is very great. Since these institutions, in order to save money, employ unqualified staff and the legislation is not providing sufficient power to stop such practice, the demand for regulation and improvement of the legislation has come from the ranks of nurses and got reflected in committee reports regularly.

THE VARDAPPAN COMMITTEE REPORT (1989)

This report, also called the report of the High Power Committee on Nursing and Nursing Profession, is very assertive on the question of nursing legislation and on the inadequacies in the existing nursing laws.

Evidently, Indian Nursing Council is almost a powerless body. It does not maintain a national register and thus does not have up-to-date information and the Act also does not make it mandatory to renew registration periodically. Worst still, its approval is not necessary for opening new nursing school or college. This aspect is significant, as normally the monopoly power for controlling education and examination is considered a big barrier to entry resulting into a limited supply of the professionals. In the case of nursing, even in the absence of such monopoly power with the nursing councils, the issue of shortage of nurses has not been addressed to. On the other hand, inspite of a part monopoly control over education and examination with the medical councils, the medical colleges have mushroomed and number of doctors has steadily increased in the country.

A major lacuna in the Act is that it does not have provision to stop unqualified non-registered nurses from practicing. It also does not have provision and power to de-register nurses who are violating its code or guidelines.

This has resulted into, as argued by the committee, employment of nonqualified women as nurses in the private nursing homes which have mushroomed all over the country. The Committee however incorrectly believed that there are laws governing nursing homes and they prohibit them from employing unqualified nurses. In fact such laws, existing only in Maharashtra and Delhi, are not properly implemented, and these laws actually allow a certain unspecified proportion of nonqualified nurses to be employed in the nursing homes.

The nurses, thus threatened by the collusion of government and the doctors or proprietors of nursing homes in undermining their professional standings, have made strong demands in the official report to provide for more powers and the strict implementation of regulation. Interestingly, here is the profession whose members are demanding powers for self regulation and autonomy with an expressed intention to use them. They are denied such privilege in the legislation and there is tardy progress in improving the legislation. This is quite unlike the medical profession which has shown scanty interest in self regulating itself but has relatively more power for self regulation. To top this, there is a considerable control over the nursing councils by the doctors (they are there by law), at places they also serve as presidents of the state councils. And, as the committee has noted, in most of the nursing councils, the elections are not held for years.

COMMITTEE ON SUBORDINATE LEGISLATION: Thirteenth report

The Thirteenth Report of the Committee on Subordinate Legislation of the Tenth Lok

Sabha dealt with Rules and Regulations framed under Indian Medical Council Act, 1956. It makes some important observations on the working of medical professionals in India and its recommendations are, in more than one way, departure from the ethical framework of medical self regulation. Although a report of this kind provides glimpse into the thinking of our political representatives, it must be kept in mind that there are a number of previous recommendations and even a bill amending the medical council act have been awaiting till consideration of the parliament. Unfortunately, given the way of working of our parliament, such recommendations and bill have not been decided upon now for years. This ambiguity in the policy related to medical profession has only created condition for disorganised growth and functioning of the medical profession.

The report of this committee, chaired by Mr. Amal Datta, has 10 sections (inclusive of introduction) and 3 appendices. It deals with the a wide range of issues such as renewal of registration, transparency of fee charged, medical records, continued medical education, advertising, lack of commitment on the part of doctors, recognised and unrecognised medical colleges and other systems of medicine. Undoubtedly, the committee showed sensitivity to many things, which are not ideal in the present day medical practice. Some of its recommendations are new and make departure from the earlier ethical framework while some do not go far-enough to touch the points raised.

Renewal of Registration and Continued Medical Education: The committee showed great concern on many important issues.

(1) The medical registers of Indian and State councils not being up-to- date due to very weak system of renewal of registration. (2) There is no provision, under the existing medical laws, for compulsory renewal of registration. (3) Although here are institutions and organisations making efforts to provide continuing medical education, the same is not tagged to the renewal of registration. (4) In the absence of the compulsion to renew registration and any law making it mandatory to update his or her medical knowledge, doctors have not shown seriousness for continued education.

Although there is a provision for renewal of registration in Maharashtra Medical Council Act, it is done in a very casual manner, so much so that non-renewal has not led to the de-registration of substantial number of doctors any time. The committee was informed that earlier there used to be a system in West Bengal where every five years the council used to send postcards to doctors and if no reply was received the council used to remove names of those doctors from the register. For re-registration of such doctors the council used to charge a fee.

The Committee recommended amendment in the Act in order to make five year renewal of registration compulsory. The committee also put the onus of renewal onto the doctors by saying that, "the doctors should inform in writing the Medical Council that they want to renew their membership."

The Committee also thought it to be correct to tag renewal with the continuing

medical education. Taking cognisance of the government grants made available to the council(s), the IMA and other organisations, and their efforts in organising courses and programmes for continuing medical education, the committee felt concerned about the less than adequate interest shown by doctors in availing of such facility. Unfortunately, the committee did not go into the details of number and quality of such programmes available for the continuing education. However, it made a strong recommendation for amendment in the Act so that participation in some courses of continuing education was made compulsory It also wanted, as it is there in some other countries, the doctors be given credits for attending such programmes. Accordingly, it recommended that a minimum amount of credit be made necessary to renew registration. It also recommended that the councils, the IMA, universities and other institutions should be motivated by the government to organise continuing medical education courses and charge for it from the participants to recover the cost. It correctly assumed that once a minimum amount of credit was made necessary for renewal of registration, the doctors would pay for their own continuing medical education.

Transparency of fees charged: The committee came down heavily on the profession for its arbitrariness in charging of fees. It criticised the present code of ethics for protecting such arbitrariness According to the present code of medical ethics, the doctor is supposed to tell his or her fee to the patient "at the time service is rendered."

The committee's concern was NOT with the quantum of fee charged. It stated clearly that it was not interested in price control or in regulation of fee charged. Its expressed concern was to explore whether it was possible to let the patient know "in advance", that is before the patient approaches the doctor, the fee charged by the doctor. Thus, it showed great concern for market knowledge of the fee charged and not for the amount of fee, which they implicitly left to the market forces. Obviously, the committee immediately found the stipulation regarding fee in the code of ethics a stumbling block. It also faced another problem. For the patient to know fee in advance in order to choose a doctor there ought to be a public announcement of the names of doctors, their qualifications, the services rendered and the fee charged for each component of services. This went counter to the restrictions put in the code of ethics on the advertising, as such announcements would amount to advertisement.

The committee thus recommended the following changes in the law and the code of ethics.

(1) There should be transparency in the fee charged by doctors and the patient should know in advance the fee for various components of services.

(2) The law should be amended to provide for publishing details about the physician (qualification, years of practice, availability and types of services rendered, etc) and the fee he charges for each service.

(3) Such details on physicians and their fees should be published (as a "Directory of Private Practitioners") by the medical council of India; every year, thus, enabling the doctors to change their fees once in a year.

(4) The council should make it compulsory (on amendment of the law) for doctors in private practice to notify, (their fees to the medical council.

(5) The publication of the council should also include the standard charges for various services.

(6) The doctor should not be allowed to charge more fees than those appearing in the said directory.

Advertising medical services provided by doctors: On advertising, the committee was cautious in suggesting reforms barring those which were in line with its thinking given above. Thus, it recommended:

(1) There is a need to liberalise the imparting of information to general public on points such as names of doctors, their fees, location of their practice, office hours, etc.

(2) It recommended that the council should make or prescribe a clear-cut distinction between advertising for public good and advertising for self-promotion, the latter of course should not be allowed

(3) It also made it clear that its recommendation for liberalisation in advertising were not for allowing for advertisement by unqualified practitioners, for magic remedies and for unconfirmed results of success

Medical Records: The committee noted with concern that the private medical practitioners in India do not keep a medical record of the patients receiving treatment from them and are not under any obligation to do so under the code of ethics. The committee made some very important recommendations on this issue:

(1) It should be made obligatory for doctors in private practice or working in any institution or hospital to keep the medical records of each patient and indicate their findings, diagnosis, prescription, and treatment actually undergone by the patient or given to him or her

(2) it should also be obligatory for the doctor to hand over a copy of such medical record to the patient on or before conclusion of visit, treatment or discharge.

(3) It should be obligatory on the part of the doctor to prescribe medicines which patient can afford

The government should evolve a system of record keeping, writing out detailed

prescription and prescribing medicines which are within the financial reach of the patient.

Clearly, as the committee touched the question of affordability of medicine for the patient, it ran into problems. It is difficult to make it obligatory for the doctors to prescribe correct medicine a majority of patients could afford without having the affordable essential drugs available on the market at cheap price. The price liberalisation does not make drugs automatically cheap. The experience is to the contrary. Thus, it is difficult to stretch advantages of transparency in fees and prices beyond a point when one is faced with the really poor patients who constitute a majority in the country. The committee, however, expressly did not countenance any suggestion of regulation or control of doctor's fee or the price of medicine It only followed a liberal logic, that if the price known, the market competition would bring it down. Similarly, it incorrectly believed that once doctors know about the cheaper drugs available on the market, the doctors would not prescribe the expensive drugs to patients.

Doctors' social commitment: The committee sought social commitment from doctors. It felt concerned that doctors were not ready to serve in rural masses. However, it did not analyse the profitability in rural medical market m comparison to that in the urban market. Nor did it evaluate past experiences in this regard. And above all, it failed to recommend substantial increase in doctors' employment at the government rural health care centres. Nevertheless, it did make some good administrative recommendations whose fate is very obvious.

The committee felt that before giving admission to the medical college, the candidates' commitment to serve in the rural areas should be ascertained.

This should be done by the Medical Council; by framing regulations to evaluate social commitment of the candidates desirous of entering medical college.

(3) One way of ensuring such social commitment was by making the candidate to work or take training in rural areas in a suitable manner.

Medical colleges: This is another area where the committee is less clear and much less committed in making recommendations. It notes with concern mushrooming of medical colleges, chiefly in private sector and having less than standard resources. It also notes that out of 146 medical colleges, 23 are not recognised by the medical council as they are substandard But it does not demand their immediate closure. Nor does it demand any retraining of doctors produced by unrecognised substandard medical colleges. Such doctors are also not registered. It takes a very convenient liberal view, namely, people should know who is a product of recognised college and who is that of unrecognised. The way to distinguish is by knowing, whether the doctor is registered or unregistered. So make it obligatory on the part of doctors to display their registration number prominently! The market logic is thus used to condone medical practice by the doctors produced from substandard colleges, without

any retraining, and without having a registration which is legally essential in order to practice medicine. This obviously condones violation of medical council act in its fundamental characteristic, the registration.

It makes a very useful and correct suggestion that the fees charged by medical colleges all over the country, should be uniform. This it recommended in order to "prevent inequality amongst students of the same course of studies."

Lastly, being a parliamentary committee, it had access to legal and other assistance from the bureaucrats. The confidence with which it has recommended changes in the Code of Medical Ethics only reinforces the point that, the medical profession in India does not have even autonomy to frame its own code of ethics. This code is obviously product of the law and rules under the law. Or is it that the medical councils have not exercised their right to frame the code as per the ethical needs, thus relegating this function to the parliaments and bureaucrats?

Further, the committee dealt only with Medical Council Act, which applies to the allopathic doctors. While it did recommend study of Indian systems and homeopathy in the allopathic medical colleges, on the whole, it neither gave even a cursory look to the medical acts applicable to Indian and homeopathic systems of medicine. I also did not make any general remark on the functioning of the councils of those systems.

3. RIGHT TO HEALTH CARE

The review of recommendations of various committees appointed since independence for understanding their implications to the legislative measures undertaken or need to be undertaken, highlight certain salient features of the legislative framework for health care in India.

First, it is clear that despite high sounding and radical rhetoric of some of the committees' reports, none of them believed that legislation providing even partial justiciable right to health care was necessary. The failure of Bhore Committee to seriously consider this point is the most perplexing. For evidently it was highly influenced by the contemporary developments in the health care systems of the UK and the Soviet Union. Its study of the health care services in various parts of the world is more exhaustive than of any subsequent committee. For it also showed acute concern for not only access but to the sound, durable, quality and professional based infrastructure for the basic health care services. The debates in the development of health care in the 1940s had shown that the simple policy level commitment of the government for making accessible health care to people was not sufficient. That it necessitated legislative measures to force the government to back the commitment with the actual planned investment and provision. The National Health Service Act of 1946 in England was a sufficient proof for translating policy into an action plan. Yet, all its recommendations are confined to creating non-legislated entitlement of services and for enacting laws only to the extent that the establishment of an administrative infrastructure for such services needed.

Second, the subsequent committees have fared worse. The primary tasks of these committees appear to be making an organised retreat from the plan for health care entitlement formulated by the Bhore Committee. A basic assumption all these committees uncritically accepted was that the Bhore Committee plan demanded investment "beyond the reach" of the government, and hence, dilution of that plan, or retreat from the commitment of providing health care to people irrespective of their capacity to pay, was a foregone conclusion. Interestingly, the starting point of these committees' deliberation was the paucity of funds, and little attention was paid to explore alternative ways of mobilising finances for implementing the plan. The rich international experiences in various countries for using different means of mobilising finances for the health care were not even reviewed.

Third, this led to experimentation in changing administrative structure, designations and works assigned to health workers, creation of new categories of paramedical workers and so on. From the early 1960s to mid 1980s, rapid changes of this kind were made, upsetting the work at the Primary Health Centres (PHCs) and confusing

health workers. Our studies at the (PHCs) have found that such frequent changes and attendant administrative chaos have contributed substantially in making health workers less serious about their work, particularly health work. Such frequent changes were made possible, as they were simple policy decisions, not converted into legislative enactment. The legislated changes would have at least made it difficult for the policy makers to react to the situation the way they did. While it could be justifiably argued that by not legislating, the policy makers gained flexibility, the argument in the reverse is equally valid. Too much of flexibility, so much so that measures are simply taken without taking fall stock of the situation and primarily to show that something was being done, could be highly unscientific, upsetting and counterproductive in establishing a well organised system of health care.

Fourth, most of the committees did not take cognisance of the private sector and did not recommend anything substantial in order to make it participate in the planned development of people's entitlement to health care. The parliamentary committee on subordinate legislation perforce dealt with it because over 80% of doctors are in private sector, but it did not examine its recommendations in light of the plan for the development of health care services. These reports give a strong impression that at no time the judicious mix of public and private provision of health care was seriously and in a holistic way ever contemplated. The public and private sectors were treated separately, to an extent even justifiably. But this was stretched to an extent of being unreasonable and irrational, as the inter-phase of these two sectors and the implications of uncontrolled growth of size and expenditure in private sector on the overall development of health care were ignored.

Fifth, similar unhealthy separation is created between the allopathic and other systems of medicine. Neither are attempts made to bring about the promised integration, nor are serious and definite efforts made to develop Indian systems as separate but genuine and formidable sciences. 60% of all doctors practising in our country are formally educated and registered in non-allopathic systems of medicine. They are almost ignored or excluded from the discussion on health policy, so much so that whenever official figures of number of doctors are given by the ministers and others, only the number of allopathic doctors announced to emphasise that our country does not have enough doctors!

Sixth, despite recommendations of the Bhore and the Mudaliar Committees, a comprehensive and consolidated enactment of Public Health Act covering the whole country was ignored. While some of the recommendations on this act are integrated in the health care administration, the basic problems of not having a consolidated legislation have continued. As a consequence, there is less transparency in the way health care is administered, the scope for people to use "activism" of judiciary to push it for better efficiency is simply not available and above-all, the minimum standards for assuring quality health care have languished as administrative orders, sparingly implemented.

Lastly, despite people oriented rhetoric of most of the reports, care is taken not to provide even marginal rights to people for asserting their needs. While it is true that mere legislation is not sufficient to create people's initiative, it still functions as a partial right granted, a policy translated into formal commitment. It at least provides an opportunity to people to use it as an instrument, howsoever inadequate. The legislation also makes it difficult for the government to withdraw that right by passing an administrative order. The legislation thus makes the commitment more political than a policy statement.

Thus, in essence, the measures taken so far in developing health care services in India could be described as attempts at creating entitlement, and not the right to health care. The debates on health care have unfortunately not gone beyond the deficiencies in the creation of entitlement. It has hardly produced concrete suggestions for providing the right to health care.

Justiciable right to health:

There are varieties of rights given to people, by law or recognised by law: (1) Fundamental rights given by the constitution, (2) Constitutional rights not having status of fundamental rights, (3) Statutory rights, (4) Rights flowing from subordinate legislation. (5) Rights based on case law, (6) Customary rights, (7) Contractual rights. (Bakshi, 1994: 51)

The objectives specified in the preamble of the constitution document contain the basic structure of our constitution. Along with the preamble are the Part III and Part IV of constitution containing Fundamental Rights and Directive Principles of State Policy respectively. Further, the preamble can be invoked to determine the ambit of fundamental rights as well as the directive principles. The article 13 in part III of the constitution establishes paramountcy of the constitution in regard to fundamental right. Indeed, the object of this article is to ensure that instruments emanating from any source of law will pay homage to the constitutional provision relating to fundamental rights. Thus, the rights enshrined in the fundamental rights are the most important and basic for our social structure They are not only justiciable rights but are also non-violable by any law ever made in the country by any authority. It is in this context, the absence of right to basic or primary health care to the people and for that matter even right to education, remain a major lacuna.

The part IV of the constitution, the directive principles, on the other hand, are not enforceable by any court of law. However they are stipulated, as fundamental to the governance of the country and it shall be duty of the state to apply these principles in making laws. Thus, it does not have a character of being justiciable, its violation cannot be challenged in the court. But it provides certain positive features, as much as the legislation made to implement directive principles would be in all probability, upheld by courts. Not only that, the parliament can, if it wishes, and without altering the basic structure of the constitution, legislate any of the provision in the directive principle to make it fundamental right by amending the constitution. The legal experts

argue that when necessary, even the constitutional provision as to the fundamental rights should be adjusted in their ambit so as to give effect to the directive principles (Bakshi, 1994: 56).

The provision of health care is contained in the directive principles. The article 47 wherein the mention of health is made, is framed in broad terms:

> 47. Duty of the state to raise the level of nutrition and the standard of living and to improve public health:- The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the sate shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

Thus, the article 47 of the constitution under the directive principles of state policy defines health in both general terms as well as specifically in terms of health care. Conceptually, this is a great advantage, as the healthy living is not construed as issue of medical care but primarily also of good nutrition and living standards. This provides a wider scope for legislating on the issue of health and health care. The parliamentary amendment of the constitution to incorporate a well-defined minimum level of health care as a fundamental right may be an ideal thing to happen. However, in its absence, a simple legislation giving such a right would be as well enforceable, although its repeal or violation by the parliament and constituent states may be easier.

The Constitution of India also defines the relationship between the Union and the States. The article 246 gives three lists with specific areas of law making by the parliament and the state legislatures, namely the Union List, the State List and the Concurrent List. The Concurrent list contains items on which both of them have the power to make laws.

The directly health care related items do not appear at all in the Union List. In the State List, the major directly health care related item is No. 6: Public health and sanitation, hospitals and dispensaries. In the Concurrent List three directly health care related items are given: 19: Drugs and poisons, 26: Legal, medical and other professions, 29: Prevention of the extension from one state to another of infectious or contagious diseases or pests affecting men, animals or plants.

Of course, there are other items which are related to general health and other matters.

Looking at the lists an impression is often created that it is not possible for the union government to reform the health care system and, make a minimum level of health care universally and freely accessible to people in the country. The reason advanced is that the health is a state subject, and thus the union government cannot, beyond a point, do much to introduce through law a new system. There is no doubt that there are certain limitations on the union government on making laws in the field of health care. It can make laws, and some of them are already made, on the items available in

the concurrent list. For the rest, it will be required to wait for the state government to ratify its decision.

However, as we would see in the case study of the health care reform in Canada, there are various ways in which the reforms could be introduced even when there is no provision for the union government existing in the constitution of making legislation in the field of health care. In the case of India, unlike Canada, there is ample scope in the constitution for the central government to make laws in many areas of health care. Besides, the health care system is also an economic system or subsystem. The reforms for making health care universally available, is also an economic reform. And the union and concurrent lists provide enough scope for the central government for undertaking reforms in the economic organisation of health care. The items like insurance, social security, social insurance, price control, etc are also for the union government for making laws. It should be noted that in Canada in the absence of such provision on health care in the constitution, the fiscal arrangement between the central and state governments played a crucial role in ultimate enactment of desired legislation for national health insurance. In the USA, the Medicaid and Medicare programmes were enacted as a part of the existing social security law.

In brief, the directive principles give full scope to the parliament to make right to health care a fundamental right. Besides, in the absence of a will to make it fundamental right, there is also a scope for enacting a simple but comprehensive legislation for making right to health care an effective practical reality.

Our limited survey of right to health care suggest that in all market economies, including in those where strong national health service or national health insurance systems exist, there is no absolute and unlimited right to health care. In other words, none of these countries, despite legislation for establishing national health services, provide any legally enforceable right to health care actionable by an individual patient for his or her own health care benefit. To this extent it is correct to assert that translating policies into legislation does not automatically provide more right to people than in those situation where policies are not legislated, as is the case in India. Then, what does the legislation achieve in providing right to health care? To what extent legislation help? And lastly, what types of legislation are essential in order to expand people's right to health care?

Right to health care in the UK:

Margaret Brazier (1992: 20-22) while reviewing the national health service (NHS) of the UK and the right to health care, explains that the NHS Act, the Health and Social Security Act and the NHS and Community Care Act, are largely concerned with the constitution of services. The Acts create authorities who administer the health service, and provides for the services available and payment to those who administer them. A mass of administrative orders or circulars produced continuously by the authorities cover a number of issues affecting patients' rights. Although such a mass of circulars is less accessible to common people, they are important for patients for initiating

malpractice action. Besides, if any of the circulars is found to be in violation of certain rights, it could be challenged in the court of law.

The NHS confers a duty on the Secretary of State for Health to promote comprehensive health care. He or she is supposed to provide services to such extent as he or she considers necessary to meet all reasonable requirements for a whole range of services. This does not mean that a patient can compel the authority or the minister to provide a particular service for which resources are not available, or shorten the waiting time or compensate for the pain and suffering due to unduly lengthy waiting time. The courts have held that

(i) The financial constraints to which minister was subject had to be considered in assessing what mounts to reasonable requirement for hospital and medical services;

(ii) The decision as to what was required was for the minister, and the court could intervene only where a minister acted utterly unreasonably so as to frustrate the policy of the Act.

Litigation against the local health authority to compel it to provide service otherwise not normally provided by the NHS in a particular locality or institution, have failed in the Court.

Thus, in the British NHS, the absence of any right to health care has many adverse implications. The authority could withdraw certain services under the plea that funds are not available. It could refuse to start new services even if it is a real need of the community. The NHS Act, it seems, also does not define minimum components of services which the authority must provide under any financial or other difficulties.

However, the existence of the Act has certain legal advantages. While the Court have refused to compel authority for making provision of services demanded, it has right to scrutinise the reasonableness of health authority's decision. This has been possible because there is a specific legislation providing scope to the court to interpret policy behind the act. Unfortunately, from the available literature with us it seems that the scope and readiness of the court to scrutinise reasonableness of authority's decision, are not tested so much in litigation. This is perhaps because most of the cases demanding right to services were for certain high cost services or their provision necessitated establishment of costly infrastructure. None of the case pertains to the provision of the basic services, which apparently is not so far significantly compromised by the authorities. However, it would be interesting to know, how the court would interpret "reasonableness" in the event of the authority deciding to allocate extra funds to a high cost super-speciality services to the detriment of the low cost services in general wards (as it seems to be happening in India). In other words, can the authority stop a service, which is needed for larger number of people in the community it serves in favour of providing service needed by few in the community? Since the existence of the Act provides scope to the court to scrutinise reasonableness of the decision taken by the authority, the enthusiastic litigants and the active

judiciary have a scope to expand the boundary judicial intervention in the decisions of authority.

The second important power retained by the court is that once patient is admitted for care, the health authority is duty bound to provide adequate care. If it does not provide necessary care and the patient suffers from some injury, the patient can demand compensation.

Clearly, the existence of the NHS Acts could bring the courts in the picture in certain cases. Same would have been difficult in the absence of such an Act.

Canada: National Health Insurance:

Canada does not have a text of constitution, but it derives its constitutional law from the Constitutional Law of 1867, which created the federal state of Canada under a constitutional monarchy of parliamentary type. As is the case in many countries, the Canadian constitutional law does not contain specific reference to health and health care. The only reference that is made in some articles is related to the distribution of powers between the federal and provincial governments regarding certain public health matters. In fact, in the Canadian federal set-up, historically, the courts played an important role in defining powers of the federal and provincial governments on various matters including health. In this legal debate, and in its orders, the courts invoked the constitutional clause, which put all matters of local or private nature within the domain of provincial governments and thus, prevented the federal government from making organised intervention in the field of health and social welfare. For instance, during great depression period, the federal government passed a law on employment and social security, 1930, but the courts invalidated it using these provisions. In fact, this law had also empowered the federal government to appoint a commission to study health insurance.

The situation changed in 1940 when the Constitution Law of 1940 amended the Constitution Law of 1867, and granted, (1) the parliament an exclusive power concerning, unemployment insurance, and (2) the federal and provincial governments powers to enter into agreement(s) concerning health. Thus, without including health as a right of people in the Constitution, a way was cleared for the federal government to make laws for providing health care to people and get support for them from the provincial governments. The rest of the history of the Canada revolves around the political process, which ultimately made it possible for it to usher into the national health insurance. This process was not easy, though. In 1940s, the provinces thwarted attempts made by the federal government, as they did not agree to the proposals on sharing of the expenditure between the federal and provincial governments. However, some provinces went ahead with the hospital insurance, and the federal government supported them. Ultimately, after long process of give and take, and after overcoming strong resistance from the medical profession, the Law on Hospitalisation and Diagnostic Services Insurance, 1957-8, and the Law on Medical Care, 1966-7 were passed by the parliament and brought into effect.

At formal level, these laws did not confer any constitutional fundamental right to health care to Canadian people. However, in their scope and in practice, they actually did. According to these laws, the federal government committed to share half of the cost of providing universal health care by the province. They also laid down the preconditions to be met by the provinces in the field of health care in order to join this programme and to continue getting the federal share. This in effect, motivated provinces to upgrade and reorganise their health care services in order to join the programme. Thus, after passing these laws, it took few years for all the provinces to become eligible for joining.

Thereafter, the federal provincial relationship ran into trouble only on the questions of rising cost of health care and its sharing by the federal government and on some provinces charging for a part of the service from patients. This necessitated adoption of a comprehensive federal law called Canadian Law on Health on April 17, 1984. This law replaced the earlier two laws. Accordingly, in order to receive the cash contribution from the federal government for the cost of health care the provinces must comply with the following conditions:

(a) Public management of the provincial system of non-profit health insurance.

(b) Comprehensive coverage by services included in the insurance under the federal law.

(c) Universal coverage of all inhabitants of the province under uniform conditions, with certain exceptions.

(d) Possibility of transferring benefits of the insurance system from one province to another.

(e) Accessibility of health services without any conditions, such as billing the insured.

These five conditions form the core of the Canadian system, and all provinces of the country have entered into an agreement with the federal government to abide these conditions. The condition (a) clearly rules out the role of private for-profit and non-profit organisations or insurance companies. This condition has historical roots in the pre-national insurance Canada where, like in the USA there were many health insurance organisations, including those run by the medical profession. Interestingly, the medical profession had in the 1940s and 1950s, fought bitter battles to channelise the financing of new system through such organisations. This conditional thus shows economic and political wisdom of keeping out such organisations. The condition (b) provides for the quantity of services to be given on uniform basis and its standards. The comprehensiveness of health coverage ensures that a certain quantity of service is available to all, and that, under any pretext it is not diluted by any province. The condition (c) provides that all people are covered. Interestingly, it uses the term

inhabitants and not citizens. The condition (d) takes care of inter-province migration of people without losing benefits. And lastly the condition (e) prohibits user and other fees at the point of delivery. This removes the financial barrier at the point of delivery to access almost completely.

Thus, for the subject of our discussion, such system provides for

(1) Creation of such services,

(2) Creates entitlement for people covered by the system for a minimum level of hospital as well as Medicare services,

(3) However, the entitlement is subject to resources available. Thus the queue at the time of actually availing of the services cannot be dispensed with, and the decision to provide for newer service or withdraw existing service is taken at the political level. And such decision cannot be taken unilaterally by the federal or provincial government.

Thus, both in the NHS and the National Health Insurance systems, the authority are not legally bound to make available a service that it cannot afford. At the same time, the decision of the government not to provide a service on financial ground cannot be arbitrary as the courts could be invoked to consider any demand made. In any case, in both cases, it seems that the right to already available service is implicit, more so in the Canadian model where the statute itself ensures a minimum provision.

This right to the already available service is again tempered by certain factors. For instance one cannot demand immediate attention for service, unless it is a medical emergency. The patient may have to wait in a queue, say for a planned operation. The position in the queue is determined by the medical criteria, and not by one's ability to pay. Thus, in essence, these systems do create a legal or statutory (and thus, even constitutional) entitlement to health care, but such entitlement for the individual is not absolute and unlimited. This goes well with the liberal democratic ethos, where the democratic rights are always circumscribed by reasonable constrains, particularly to avoid infringement of others' rights. Apparently, such an arrangement providing for the legal entitlement to health care without giving unlimited and absolute right to health care to individuals is not uncommon in other Western European countries. (Fuenzalida-Puelma, Scholle, 1989).

Lastly, in must be understood that legal entitlement to health is not possible to codify. For health is much wider concept, the attainment of it is not possible merely by making provision for health care. What is important to understand that the creation of uniform barrier-free legal entitlement to health care, through some legislation or by making it fundamental right in the constitution, is a step forward in legal recognition of the right to health. Thus, "although (in Canada) the right to health and health care is not expressly recognised in the Constitution, the laws and the existing provincial

and federal programmes concerning health insurance social services establish that right in practice." (Emanuelli Claude, 1989:158)

Right to health care in the USA:

As we know, unlike Canada and many Western European market economies, the US has opted for private sector based health care provision. Lot has been written on the burgeoning cost of health care in the US. It is interesting to note that the proportion of health care expenditure to the GNP in Canada and the US were almost identical (at about 7%) in 1971 The expenditure in Canada has since than stayed around that proportion only, but that of US has almost doubled. Despite having Medicare and Medicaid programmes started way back in 1965, the private provision health care system is plagued by increasing number (millions) of citizens who are uninsured or under insured. While health is a hotly debated issue in the US politics, the political leadership has not been able to exhibit necessary will to reform the system to make it easily accessible to all citizens of the country irrespective of their level and capacity to pay for it. Thus, the most modern and the most expensive health care system in the world promises everything except its access to a sizeable proportion of its citizens!

The US constitution and legal system are historically tied to an economic philosophy, which emphasises private markets and limited governmental intervention in the economy. As a consequence, the health care, like most other aspects of living, has been treated as a consumer item sold by private parties. Due to lack of a single guiding hand, many subsystems have developed, creating what has been called a fragmented, overlapping and unplanned delivery pattern. The components of the delivery pattern are so diverse that, Morgan Capron (1989: 503) finds it difficult to call it a system, for the term system may be too elaborate for the manner in which health care is provided and funded in the US.

Curran and Hyg (1989) has briefly but succinctly summed up the existing situation on the constitutional right to health care in the US. While Medicaid and Medicare are statutory programmes, they are aimed at the indigent and aged. They are not intended for uniform coverage. Further, they also provide a pre-decided range of services. Thus, there is no specific statute in the US, like NHS Act in the UK or the NHI Act of Canada, to make it legally obligatory on the authority appointed by law to make uniform provision of health care services to all citizens of the country. Earlier in the 20th century it was established in the courts of law that the US constitution contained no provision, either in the body of the document or in the Bill of Rights, for citizens of the country to claim a minimum level of health care services. Interestingly, the Medicare and Medicaid programmes were not established in 1965 by passing any specific statute for them, but were extensions of the Social Security Act of 1935 which has established the concept of federal grants-in-aid to the states for health purposes.

There are three other field of health where some legislative measures have been taken in the US Firstly for planning of health care. The laws passed and programmes

initiated included the regional medical programmes act, 1965; comprehensive health planning programme, 1966; the national health planning and resources development act, 1974 and so on. However, these attempts have not yielded substantial positive results as they had little regulatory authority and political will to back them up. The second area of legislative and policy concern in the US has been the cost containment. The establishment of professional standards review organisations, 1972 and the development of health maintenance organisations for this purpose have done also not yielded desired results. The third area of increasing competition in health care was highly talked about in the 1980s. In fact, till 1970s, using legal means to promote market competition in health care was not heard of. But in 1980s, the deregulation policies were in ascendance and the courts cleared way for the application of antitrust laws to promote competition. But soon the deregulation and competition came under attack, for they hindered cost containment and quality.

In brief, in three fields, the legislative and policy measures initiated to control negative impact of market based private provision of health care have not succeeded in creating desired balance. This only shows that without creating a political and legislative framework for the universal access to health care, the laws passed and policy measures initiated in a reflex and piece-meal way do not help in reforming the health care for desired ends.

Further, the US law has a curious element, though such element is very consistent with its dominant liberal and market based political philosophy and system. It has provisions for making it legally obligatory on the government to provide optimum and adequate level of health care services free of any cost to certain type of individuals, viz. (1) Convicted and confined prisoners, and (2) Involuntarily committed mental patient. The free service to the latter also includes right to psychiatric care.

Thus, in the US one ought to be a criminal who is caught or a mental patient who is a public nuisance, in order to have a right to free and adequate health care! The ordinary citizens, even the tax paying lot, cannot have it as a right. The criminals and the insane are given such right as by confining them, their liberty has been snatched away. That makes them incapable of having private initiative to provide for their own health care.

Curran and Hyg (1989) have lamented over the fact that very few lawyers have, in the US, attempted to prove through litigation that there is a general constitutional entitlement to health care services. The courts have on the other hand, resisted raising the issue on their own. Thus, the US law is not so well developed on this subject and the Courts have come under little pressure to take position.

Nevertheless, though the citizens in the USA do not have a legal right to health, nor the government a legal obligation to provide health care, howsoever minimal, on demand, the development in case laws and enactment of statutes in few states have

created some space for the needy citizens. This right is for the emergency services. The entire position may be summarised as follows:

(1) In a case needing emergency services, it was argued that since the county was providing emergency services, the patient has a constitutional right to medical services at the hospital of patient's choice and by the doctor of patient's choice. The court did not entertain such a demand and the right. The court made it clear that the fact the county had made "some ambulance service" available to the public did not constitutionally oblige it to perform whatever emergency services plaintiff requested or desired. (Curran and Hyg, 1989: 789).

(2) The US law makes distinction between a situation in which county government itself placed the person in danger and one in which the county merely failed to help someone already exposed to peril for no fault of the municipality. Thus, the emergency condition of danger to life did not give rise to constitutional right to adequate emergency medical services.

(3) Some of the States in the US are indeed improving their legislation. For instance, the Illinois Medical Emergency Treatment Act legislatively imposes obligations on general hospitals, both public and private, to offer emergency services to the public (Curran, Shapiro, 1982: 650). While such statutes legally create obligation for providing emergency medical care, some cases fought in the courts have helped develop case law for establishing such an obligation. Curran and Shapiro cite a case (Wilmington General Hospital vs Mairiove) in which the court imposed duty as a common law obligation based upon the voluntary effort of the hospital in operating and publicly displaying an emergency ward. The public could therefore rely upon receiving needed service and could not be turned away Thereafter, in Guerro vs Cooper Queen Hospital case, the private hospital argued that it is under no obligation to accept any individual who applies as a patient. This point was not disputed, but a case was made that while a private hospital may not have a duty to accept any individual as a patient, it has an obligation to provide emergency care to all persons presenting themselves for such aid, including non-resident aliens. The court held that in emergency, refusal to accept a case by hospitals, including private hospitals which are maintaining emergency ward(s), would lead to worsening of the seriously ill or injured person, because of the time lost in a useless attempt to obtain medical aid. If such a refusal had led to aggravation of injury and suffering, it would be a case of the negligent termination of gratuitous services, which creates a tort liability. (Ibid, 644-5).

Thus, the development of case law, and of course in the peculiar US characteristic of fear of huge monetary damage due to malpractice litigation, a right to emergency medical care to needy patient has been established in the US.

While such development making adequate emergency service accessible is commendable, the court decisions in such cases are very forthright in stating that the public authority have no legal obligation to provide health care services to all citizens,

except those with whom the authority has entered into a "special relationship". And indeed, the cases of such special relationship include, for instance, a person under substantial degree of forced confinement or custody as his/her ability to seek and obtain health care privately, is eliminated by that authority.

Curran and Hyg (1989: 789) say that court judgements in various cases have put strong barriers in the way of those who would argue for the establishment of a constitutional entitlement to health care services. They have created barriers in forcing reluctant legislatures and state and municipal agencies to provide more adequate, widely accessible programmes of health care. They conclude, by saying that the only other constitutional or legal remedy remaining in the USA would be to amend the constitution formally to establish such a new civil right.

Lastly, from the above review, it appears that the present constitutional provisions and the legal framework have brought the US health care to a dead-end. This could be broken only through changed political climate and conscious political initiative by creating genuine practical, concrete, minimal and above all uniform entitlement to health care for people in the US.

Constitutional Right to Health Care: A Survey of the Americas

The Pan American Health Organisation published in 1989 an extensive analytical comparative Constitutional study of right to health in Americas, edited by Fuenzalida-Puelma and Scholle Conner, and covering all Latin countries. Barring Canada and the USA, the rest of the countries are underdeveloped countries. Their findings and conclusions are of great interest.

Accordingly, in 20 out of 35 countries surveyed, a right to health and/or state's duty to protect health has been enshrined in their constitutions. A right to health or health protection is included in 13 constitutions (Bolivia, Chile, Cuba, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Paraguay, Peru, Uruguay, Venezuela). The duty of the state to protect health is found in all those countries that speak of a right to health and directly or indirectly, in six others (Brazil, Dominican Republic, Ecuador, El Salvador, Panama, Surinam). However, the wording of provisions related to health show little uniformity, either among themselves or to international context. Only one country case study author (Venezuela) claimed that the constitutional right to health is subjective and immediately judicially enforceable (Fuenzalida-Puelma and Scholle Conner, 1989: 622-3).

Analysing the country case studies, the editors concluded that the actual implementation of these constitutional guarantees was, however, a matter of regulating law and public policy. Effectiveness depends on legislation, political will and commitment of resources.

Further, the meaning of right in practice depend upon whether right is declared in an operative or programmatic norm. A right to health as an objective of the state's long

term goal, stated in the text of constitution, as it is in the constitution of India, would qualify the country having constitutional right, but without any operating law and political will and resources to translate the right into practice. On the other hand, the practical legal right, whether enshrined in constitution or not, backed up by commitment of resources, would create a ground for actual realisation of that right, fully or partially.

Right to health care: Concluding remarks

What does one learn that is useful for our country from these examples of developed countries? One issue is clear, although efforts are not made by lawyers in our country to develop case law for ensuring partial or full, legal or constitutional entitlement to health care, we should not expect more to come out of those efforts. Some legal experts told us in discussion that if we could get what people got in the US for the emergency services, we should be thankful to courts. They added further that, given lengthy delays in obtaining justice, high cost, blind faith in doctors and their costly equipment, and social stigma attached to the litigant status, the case law has not adequately developed even on medical malpractice. Not enough number of litigants for medical laws have been around till recently to make that possible. And given the tardiness in implementation of anything, law and judgements included, some of such judgements would not instil fear amongst private and government providers to change their ways. This is a highly depressing scenario indeed.

Another thing we learn is that given the inadequacy of constitution of ours on the issue of right to health care, the easiest way to create some right is by enacting a law. The point is, a legislation creating some right to health care, or imposing some obligation of providing health care services on the government, would give a socio-political advantage to the needy people. The focus of the debate would radically change. Today, we are spending reams of papers to discuss right to health care. A legislation would change it to right to how much of health care, as is the case in the UK and Canada and in many other countries. As explained by us above, it is unlikely that there would ever be a right to absolute and unlimited amount of health care in all cases and in all situations. Every right is circumscribed by certain reasonable limits, including fundamental rights. So would be the right to health care. Yet, a legislation making health care accessible would create popular pressure and participation for improving access and also the access to the adequate health care. There is no reason to believe that an underdeveloped country like ours cannot provide at least basis health care services as a right. The present day in-access to health care is not due to scarcity of resources for basis health care services, and therefore it is unjustified.

4. LAW, ETHICS AND MEDICAL COUNCILS
History and Concept

Medicine: Trade or Profession?

In last few years, this question has been asked to the Indian doctors numerous times by all kind of people. The response this question has generated is very intense. In the present context of commercialised medical practice, there is a strong public feeling that the doctors have become traders. The doctors on the other hand have reacted in a contradictory manner. Some have found the label trader too offensive to continue debate on the subject. Some have at least implicitly accepted that a big part of the present day medical practice is nothing but trading by qualified as well as non-qualified medical practitioners. That is the reason why the latter category of doctors have, when cornered, said umpteen number of times that, "we are not alone doing it" or that "we are a part of the society which is commercialised, so why blame us alone.'" Thus, in essence, to be professional in our country has been reduced to two major characteristics; first, unlike lay trader, the professional is highly educated, qualified and skilled; second, it does work for maximising income. In fact, the meaning of the term professional, which once gave a sense of pride to doctors, has actually changed in the language of some doctors. They themselves seem to define it, often without realising it, as a trade. Nevertheless, there is a great sense of unease amongst a big section of doctors if they are called traders or the meaning of the term professional is construed to be a trader.

The word profession is derived from the original Latin *profitee*r which, conveys a meaning of making public statement of commitment, promise, announcement or confession. When one refers to a dictionary, one finds that the meaning is related to learned occupation and the religious belief. No doubt, the profession is not merely an occupation of highly learned and skilled technicians, but it also includes a strong and inseparable moral public commitment. In medicine, this morality, avowal, the public commitment has behind it a tradition of many centuries. Therefore, even in a completely commercialised environment there is inevitable tension between the trading part of the medical practice and the commitment to give primacy to healing the sick. That is perhaps a reason why even in a generalised private market environment and domination of market ideology, it is not simply the wealth of doctor which gives him or her social and moral authority. A substantial part of that authority is derived from the public perception of and doctor's public declaration to follow certain ethical tradition of medicine. Thus, ethics has become both a force within and from outside shaping the contours and behaviour of medical profession. It is indeed a great regulatory tool whose potential still remains to be fully tapped.

Historically, in 18th and 19th century, the professionalisation of medicine also ensured separation of some overt trading characteristics of medical practice from the medical profession. Earlier, the doctor while healing the sick was also compounding drugs and selling them to patient at a price. This characteristic of doctor is still not completely wiped out in many parts of the world. However, in a strict sense, compounding and/or selling drugs, an overt "trading" practice, is no longer considered to be a part of the modern medical practice. It is now the job of another category of persons, the chemists who evolved from the apothecaries. Earlier the apothecaries were "lower" level of doctors, less educated, less skilled and who sold drugs directly to patients. In our country separation of work of doctors from chemists is affected by law, and whenever the doctors or hospitals have tried to store large quantity of drugs for sale to patients, the chemists have viewed it as an infringement over their occupational territory, the trading in drugs. Similarly, another trading practice of "fee splitting" or what is well known as "cut practice" is also considered outside the realm of professional medical practice.

Place of Ethics in the Medical Profession:

The practice of medicine has a special characteristic not found in so pronounced manner in other occupations. That the medical practice deals directly, and at the time when person is most vulnerable, with the immediate issues of life and death, health and illness. The dependence of patient on the doctor's technical knowledge and integrity is, thus, of highest order. The doctor's involvement with the patient is therefore special, but this relationship between doctor and patient is not equally balanced. The patient's attitude is that of trust, which comes from perceived competence and integrity of doctor, and paradoxically, also that of distrust which comes from the state of uncertainty and vulnerability. This ambivalence in doctor patient relationship is controlled by medical ethics which, is supposed to guarantee the patient that the doctor would not abuse his or her superiority in the relationship. Thus, the medical ethics is essentially a publicly announced self-regulation or legal regulation, voluntarily accepted by the doctor that, though the medical practice would be a source of his or her living, it would be practised for the benefit of patient and not for mere personal aggrandisement.

This basic understanding of medical ethics pervades throughout the medical history, both in the modern period of professionalised medicine and in the pre-professional period. The professionalisation of medicine only elaborated the scope and role of medical ethics in the practice of medicine. In order to wipe out the impression of "trading" from public mind, the professionalised medicine took great pain to severely restrict internal competition, poaching of patients, fee-splitting etc. The period of 19th century development in elaborating scope and role of medical ethics in the Western medical world is more characterised by regulation on the "doctor to doctor" relationship and "market" or economic behaviour of doctors than on "doctor patient" relationship. This was necessary in order to reassuring the society that the monopoly over medical practice given to them was not misused. In this period the profession

paid scanty attention to integrating the democratic principle of patients' rights in the explicit ethical framework.

This in fact paid huge dividends to the medical profession. It helped the profession in wiping out the "external" competition from quacks, midwifes and others on one hand and in consolidating its monopoly over the medical practice on the other. It was only in the 20th century under great pressure exerted by malpractice litigation, the wave of national health services in the European world and other factors that brought about greater public accountability of medical practice and elaboration of patient's rights in the codes of medical ethics. Interestingly, the issues of doctor's competency, systematic peer review and his/her health status as fitness to practice got elaborated only in last quarter of century.

Thus, in history there is nothing to suggest that ethics governing medical practice are unchanging fixed categories. Although the ethics are often shown as emanating from eternal morality and unchanging moral principles, in reality, both the morality and moral principles are ever evolving and thus changing material relationships between the medical profession and society in general; and between doctor - patient and doctor - doctor in particular. The concrete shape of ethics in medicine is embedded in the contemporary material social reality rather than in any abstract moral philosophy or moral principles.

Self-regulation of Medical Practice:

The concept of self-regulation is strongest in the medical profession. The only other modern profession which, perhaps could boast of more autonomy and greater self-regulation is the ministry or priestly class or those involved in the work of divinity. The self-regulation in simple term means a voluntary and internal regulatory mechanism within the profession irrespective of whether it is demanded from outside or by law. This concept dates back to ancient times, one of the traditions that is well known in this regard is the Hippocratic tradition of Greek medicine. The famous Hippocratic oath was not a legal document in the strict sense of the term. In fact, the legal or something close to legal sanctity was given to it when it was accepted by the professionalised medicine as a basis for medical ethics. In its own time, it was more of a moral code used for initiation as well as for self regulation of medical practitioners belonging to private, voluntary associations. It was a moral foundation as well as a material justification for the autonomy of the medical practice.

Same hold true for the ethical principles embedded in the practice of Indian systems of medicine. In early times, there is no recorded instance of the state codifying the ethics into the state law or codes. Even otherwise elaborate *Arthashastra* leaves this work to the internal voluntary regulatory mechanism of doctors.

The autonomy provides doctors great flexibility in their work. It creates avenues for improvisations and innovations, without which the medicine cannot progress. It also gives them authority to determine the reasonable standards of practice as acceptable

scientific practice at a given point of time. The autonomy, on the other hand, due to the monopoly of medical practice, could also make the profession to deviate from its social obligations. Using its control over medical education, it could make the entry of individuals in the profession so difficult that there is a gross short supply of doctors to the society. The autonomy could lead to more power to doctors in relation to patients and abuse of such powers. The pursuit for profit and high income could also lead to the neglect of healing objective. Such and many other ills that go with the irresponsible autonomy of the professional groups make it mandatory that in order to have autonomy, the professional group has to show all the time that the autonomy granted by the society to it is not misused. This is done through the self-regulation. In this context, the implicit existence of self-regulation is not sufficient. The self-regulatory mechanism must have sufficient transparency for being credible in public eyes. Thus, like in the case of judiciary, in the medical profession, it is not sufficient to have self-regulations, but the self-regulation must be seen as being done.

Law and Medical Ethics:

Prof. Frank Grad, a professor of law, in his article titled "Medical Ethics and the Law" in The Annals of the American Academy of Political and Social Science (May 1978), say that, "It is part of our folklore that once we were a free people, with free professionals, physicians, lawyers and others, carrying on their professions free from burden some regulations, exercising their best professional and ethical judgements, responsible only to themselves and to their professional peers, in accordance with norms expressed in codes of professional societies in which they were free and voluntary members. The historical facts do not match the folklore. Physicians have been a regulated profession for quite some time. Indeed, the practice of medicine was one of the earliest fields in the United States to be subjected to licensure and to regulatory controls concerning education and training and elements of personal and ethical fitness." Professor Grad is of course not off the mark in his assessment of the modern relationship between ethics and the law, although on face of it what he has said might seem at variance with some of the points in our preceding paragraphs. For instance, how can we talk about the autonomy and self-regulation when the regulations on the profession are legal?

It is true that absolute autonomy and moral self-regulations are nothing but folklore in the modern context. Historically, the doctors themselves had fought bitterly against the established medical vested interests and other political powers to persuade the society to promulgate laws for registration (licensure) of doctors and for getting power to have monopoly control over the medical education. The 18th and 19th centuries were marked by the struggle of doctors to get legal recognition of their autonomy and self-regulations. This of course was necessitated by the emergent new socio-political order based on private property, liberal democracy, industrialisation and formation of nation states. Within medicine, the monopoly of a small, learned group to be harbinger of medical knowledge was challenged by the emergence of scientific medicine. These factors created historical movement in the Western world,

starting from England, for affecting transition from informal, voluntary autonomy to formal and legal autonomy and self-regulations in the form of Medical Councils.

Thus, in brief, the larger framework of autonomy and self-regulation within which the medical profession is governed is also a legal framework. However, there are two broad aspects which, distinguish the medical self regulation from the law:

Firstly, within the legal autonomy, the profession, i.e. its Medical Council, has been given sufficient powers to formulate its own self-regulations. The profession does these things using its "scientific" and '"moral" expertise. The morality of ethics has therefore helped shape the codes of ethics; and thus they have strong roots in the Hippocratic tradition. The scientific expertise has of course helped in shaping the medical training and the standards of medical care. While such regulations are formulated under legally created Medical Councils, the voluntary professional associations have always played a very dominant role. Indeed, in the Western societies, the representatives of medical associations have found highly significant representation on the medical councils.

Secondly, the profession is also given power to implement the self-regulation formulated by itself. That is, the profession not only decides the details of the regulatory mechanism, but also uses its own members to implement it. Here, to use an example, the liberal democratic principle of separating functions of legislation/executive and judiciary is waived in favour of providing autonomy to the profession.

It is normally accepted as a rule that ethics is something more than the law. The formulation of various aspects of ethical code is based on the ethical principles which, are in many ways different from the legal principles. The ethics govern the conduct, and so it goes into finer aspects of doctor's conduct. Ethics and its principles also come into play to resolve recurrent ethical dilemmas in medical practice. As the occurrence of a particular dilemma increases and as its resolution in a particular way gets currency or general acceptance within the profession, over the time it gets integrated into the code itself. This creates a dynamic which makes the ethical code progressively more elaborate. The specific laws are normally circumscribed, their elaboration by the judiciary also greatly circumscribed Since the profession acts as law maker as well as its implementing agency, the elaboration by it is always wider.

The point of ethics being greater than law has a practical implication in relation to medical malpractice and the judicial remedy available. The legal recognition of medical malpractice is confined to violation of a specific law, criminal nature of malpractice and admissibility for compensation. For instance, compensation could be sought only if harm and loss is demonstrated. A malpractice not resulting into loss and harm does not qualify for compensation. However, such malpractice still could qualify as unethical conduct inviting penalty on the doctor. This way, the scope of the ethics is wider than the law.

There is another interesting relationship between the law and ethics. Since autonomy and self- regulation are merely not ethical principles but also a legal fact, the self-regulatory code has legal value and implication. Once Code, or specific clauses of the Code, is accepted by the profession as self-governing code at a given time, it becomes a legal fact and the aggrieved patients can demand remedy from the profession. It is true that Medical Council in our country, and for that matter, to an extent even in the countries of their origin (Western Europe) have shown inadequate efficiency in implementation of self-regulations. However their existence provide ample scope for patients and public organisations to create pressure to make them respect the legal obligations. For instance, Courts in our country entertain cases against the decision taken or orders passed by the Medical Councils in response to the complaints filed by the patient or his/her relatives. Similarly, on medical education too, the courts do scrutinise proper implementation of the standards and procedures set by the Councils and the government.

History of legislation for health professionals in India

As a part of the criminal procedures and for other purposes, the colonial government had, in 1871 enacted Coroner's Act applicable to Bombay and Calcutta. It defined role of medical professionals in the work of conducting autopsy and inquests. However, the laws for the creation of indigenous medical councils took many more years for enactment. In the meanwhile, the laws were enacted for the prevention of the spread of dangerous epidemic disease, for the segregation and medical treatment of pauper lepers, etc. The Epidemic Diseases Act, first enacted in 1807and still in force with amendments while the Lepers Act, 1898, was repealed and substituted by another law in early 1980s.

While going through the historical documents of Bombay Presidency in the national archives, we found that the issues of regulating medical practice and registration of deaths were taken up for serious consideration in a meeting of a committee of the Grant College Medical Society held on March 3, 1880. The meeting was called in response to a resolution passed at an earlier meeting of the society, which had asked the committee to examine the medical act of the UK to understand the extent to which it might be applicable to Bombay. In the March 3, 1880 meeting, the committee adopted a draft bill for such law. And later, on April 6, 1880, an extraordinary meeting of the members of the society formally and *unani*mously adopted it. The meeting also decided to approach the government with the draft for its enactment. The draft adopted by the society contained, amongst other things, the provisions such as:

(1) It may be called the Bombay Medical Act. (2) It should establish "the Council of Medical Education and Registration of Bombay" or in short, "The Medical Council. (3) The Council should appoint a registrar who would act as secretary. (4) The registrar's duty would be to maintain the Register. (5) Provisions for registration of persons now qualified and of persons hereafter becoming qualified. (6) Provisions on

giving evidence of qualification to be given before registration. (7) Publication of register every year. (8) Privileges of registered persons. (9) Only registered person should have right to recover charges in the Court of law. (10) The exemption to registered persons from serving on bodies such as Juries. (11) Prohibiting unregistered persons from holding certain posts or appointments. (12) Certificates signed only by registered persons to be valid, (13) Penalty for obtaining certificate by false representation. (14) Penalty for falsely pretending to be a registered person. (15) Removal of name from register on getting convicted of felony, infamous professional conduct.

In the annexure to the draft law, a schedule was attached recognising four types of qualifications but significantly, in its schedule, no code of ethics to determine infamous conduct was given.

In essence, the draft act was fashioned in a very similar way as the medical act of UK at that time. The draft clearly brings out that this attempt at regulation was for providing certain privileges to the practitioners of modern medicine. This is evident from the recommendations made for appointing only the registered practitioners in certain kind of jobs, giving them exclusive right to move court for getting the payment of charges, exclusive right to issue valid medical certificates for various purposes and so on. These privileges were indeed in order to get a part monopoly and market position for the doctor of modem medicine. Significantly, given the highly underdeveloped state of medical care system, most of the provisions related to doctor-doctor relationship were excluded or were consider part of the ethics, the code for which was not defined, but the provision for conducting inquiry and removing name for infamous conduct was kept. There was also no mention at all of the practitioners of indigenous medical system and the need for their registration. Thus, there was an attempt to curb privileges of the indigenous practitioners by the legislation demanded through the draft act of the society.

The demand raised by the practitioners of modern medicine in 1880 was met only in the decade of 1910s. The Bombay Presidency enacted Bombay Medical Act in 1912. The medical acts in some other provinces soon followed. The Bengal Medical Act and the Madras Medical Registration Act were enacted in 1914. These Acts are more elaborate, but incorporate most of the recommendations made by the Bombay professionals over a quarter century earlier. They lay down procedures for controlling medical education, registration and the penal provision on removing names of professionals guilty of infamous conduct. Although we could not locate code of ethics of the Bombay Act, we could get a copy of the code of ethics used by the Madras Medical Council. Thus, the legalisation had also led to codification of ethics which, was used for guiding doctors on ethical conduct and for prosecuting them for infamous professional conduct. The code structure of the code of medical ethics of that time very similar to the one presently used by various medical councils.

Further, there was some difference in the way procedure for conducting inquiry into the infamous conduct given in the Madras and Bombay Acts of that time. The

procedure laid down in the Madras Act is broadly same as presently available under the Maharashtra Medical Council Act. However, in the Bombay Act of 1912, the procedure is lengthy. At the end of hearing on the infamous act of doctor, if the Council was not able to pass by a majority vote a resolution convicting the doctor of the charge, the Council was required to adjourn the case to some other future dates. On those dates, the case was heard again. After the conviction resolution was passed, the similar adjournments were made in order to pass a sentence on the convicted doctor. Thus, this gave an extraordinary length of time to doctor to persuade the Council members in his favour. Further, in the event of conviction and removal of name from the register, the Bombay Act of 1912 made a provision for such doctor to apply for re-registration. For such re-registration, the doctor was required to get certificate of good conduct from other practitioners (at least two) and the justice of peace. All in all, the Council was empowered to reregister him after giving due consideration to his good conduct. Interestingly, such re-registration procedures, involving certificate of good conduct, did not appear in other medical council acts and in their subsequent revisions. The Bombay Medical Act also dropped this procedure in its new incarnations

These provincial Acts were immediately followed by the Indian Medical Degrees Act, passed by the Indian Legislative Council and approved by the Governor General in 1916.

The laws for other professionals were enacted in few years after doctors were brought under the regulation. It is important to mention the regulation and registration acts for nurses and midwives. The nurses were trained in India from the third quarter of 19th century. In the last quarter of 19th century, there was a significant increase in their number. The early years of the 20th century saw the creation of the first professional organisation of nurses in the form of the Trained Nurses Association of India (TNAI) in 1908. Then the first quasi Nursing Councils, namely, the Bombay Presidency Nursing Association (BPNA) and the North of India United Board of Examiners for Mission Hospitals, were formed in 1909. The object of BPNA was to coordinate various attempts at nursing training and to obtain a uniform system of training by inspecting schools and by prescribing the curriculum. It also conducted examinations and registered successful trainees. The first Nursing Journal, called the "Indian Journal of Nursing" also began its publication in 1910

Thus, the pressure from the nursing professionals for the legal recognition and registration increased. The nurses in England were by that time making more concerted attempts for legal registration, and after a protracted struggle they won only in 1920. After the enactment of law for legal registration of nurses in England in 1920, the laws for legal registration of nurses were passed very quickly in India. The Madras Nurses and Midwives Act was passed in 1925 while the Bombay Nurses, Midwives and Health Visitors Registration Act was passed in 1935. Thus, while it took more than a half a century for the introduction of legal registration for doctors after it was done in England, the same happened in half a decade for nurses after legal registration for nurses was introduced in England.

While going through the historical documents, we also found that the select committee of the legislature had in 1924, while discussing the bill for the Madras Nurses and Midwives Act, recommended that dais should also be brought under the purview of act and thus provided registration. The bill defined dai as an untrained woman practicing profession of midwifery It recommended maintenance of a register for them and that no dai other than a registered dai should be employed by a registered medical practitioner subsidised by the government or local body. This provision on dais was perhaps kept simply because under the government programme for Madras Presidency providing subsidy to doctors for locating their practice in the rural areas, there was a provision for making payment to the untrained midwife or dai. Undoubtedly this provision gave an excellent opportunity to for retraining or further training of traditional birth attendants. However, this provision of recognising dai's services to the society was dropped in all subsequent legislation on nurses. The subsidy programme in the Madras Presidency also suffered setbacks in few years after the act was passed due to economic depression and the second world war.

Interestingly, even in 1970s when the government, under the high sounding orientation to community health, launched a massive programme for the training of traditional birth attendants, the dais, not even lip-service was given to the issue of some kind of registration for them. They were just trained and left to fend for themselves. The NGOs who pioneered the training, on the other hand, did not take up the issue of properly linking the dais to the government health infrastructure or made any demand for their registration.

The Indian Medical and Nursing Councils:

While laws for creating provincial councils were passed, the creation of Medical Council of India look longer time and more efforts by doctors. As Jeffery (1988: 160-73) has suggested, before 1920, there were very few doctors in the nationalist movement. The main concern of those and of other doctors till 1920 was with the access of Indians to the Indian Medical Service and with its reforms. However, after the arrival of Gandhi in 1920 in the leadership of nationalist movement, the focus changed to two main issues. The first on of them was the recognition of Indian medical degrees abroad and the second about the systems of medicine the government should be supporting

The issue of recognition of Indian medical degrees immediately brought into focus the fact that constitution of provincial medical councils had still not created uniformity in the standard of medical education across the country. It was realised that in order to achieve that, the legal constitution of medical council of India was a must. The constitution of the provincial medical councils had also given lots of privileges to the doctors of modem system of medicine at the detriment of the practitioners of Indian system who lacked any firm legal status. Thus, it was expected that the practitioners of Indian systems of medicine would make their own efforts to elevate their position, and their concerns were articulated strongly in the nationalist

movement. These concerns brought about a movement for the establishment of colleges for training in the Indian systems and for the legal recognition of doctors trained in the Indian systems of medicine.

The Medical Council of India, a national level statutory body for the doctors of modern medicine, was constituted after the enactment of Indian Medical Council Act, 1933. The first legal recognition and registration for the Indian Systems of medicine came when the Bombay Medical Practitioners' Act was passed in 1938. It was only after independence that the practitioners of Indian systems of medicine and homeopathy could have their own separate national Medical Councils.

The fate of the nursing profession was the same. While the colonial government began the province level registration for nurses and midwives in 1920s, no prompt actions were taken for establishing such legal framework at the national level. The Indian Nursing Council Act was passed only in 1947.

Thus, the legal registration and regulation of health care professionals took long time. In the next chapter we shall discuss the present legal provision and then analyse findings of our study of the actual implementation of the provisions.

5. LAWS FOR HEALTH CARE PROFESSIONALS

Medical practice in India is not covered by any omnibus legislation. There is no single legislation covering all aspects of medical practice. The laws affecting medical practice cover a wide range of areas. Some of these areas are:

(i) Medical Education: This topic again encompasses a number of issues right from recognition of qualifications, recognition of educational institutions, the courses of study, right of admission and various other aspects concerning rights of medical students, etc.

(ii) Entitlement to medical practice and the limitations of the same: What does a given degree entitle you to practise? Can an allopathic doctor prescribe Homeopathic medicines, etc.

(iii) Control over medical practice: Machinery which will ensure the enforcement of the laws referred to above.

(iv) Obligations of doctors and medical ethics: The obligations of doctors to other doctors, to patients and to the society are codified in the code of medical ethics.

(v) Medical malpractice laws: These deal with malpractice and negligence and the machinery to bring doctors to book such as Medical Councils, Consumer Courts, etc. A small part of medical malpractice accompanied by the unethical conduct is covered under the medical council acts while the rest falls under the tort law, criminal laws and the consumer protection act. The latter are discussed in the separate chapter.

(vi) Drug dispensation and Drug laws: These are covered under the acts for pharmacists and the pharmaceuticals. These are not discussed in this report.

(vii) Control over hospitals and Nursing Homes: These are discussed in the separate chapter.

Medical education, rights of practitioners and the control over practitioners are the three central areas affecting the practitioners. Different laws have been enacted covering different branches of medical practice. For instance, there are separate laws governing medical practice concerning modem medicine; Homeopathic medicine; *Ayurvedic*, *Unani* and Siddha medicines; Dentistry, nursing, etc. Besides, medical practice forms part of the concurrent list of the Constitution. This list includes those items for which the Central Government as well as the State Governments have the power to enact legislation. In practice therefore what has happened is that each aspect of medical practice is governed not only by a Central Legislation but also by State Legislation of various States. They, of course, do not run parallel but complement each other. The point, however, is that though the broad principles governing all

kinds of medical practice are uniform across the country, there are differences (at times somewhat significant) of details.

It should also be kept in mind that apart from the medical council acts, there are other specific regulatory laws passed from time to time by the parliament or the state legislature using the provisions contained in the concurrent and the state lists of the constitution. Thus, the Medical Termination of Pregnancy (MTP) Act, Organ Transplantation Act, Prohibition od Sex Selection Acts etc are essentially the laws for regulation of medical practice in those specific area. For instance, while the MTP Act is often regarded as a law liberalising abortion, in legal terms it is NOT a Women's Right to Abortion Act, but a law mandating induced abortions to be conducted only at the legally registered centres by the legally registered providers. It sounds like an abortion act simply because it provides somewhat liberalised conditions for which the providers can conduct induced abortion.

Medical Council Acts: The other important aspect is that though different branches of medicine are governed by different Medical Council Laws, the scheme of all these Acts is nearly the same. Broadly speaking, all the Acts deal with the following aspects of medical practice:

(i) Medical Education; (ii) Recognition of institutions eligible for providing medical education; (iii) List of Degrees and Diplomas which are recognised and which alone entitle a person to practice medicine; (iv) Registration of eligible practitioners; (v) The rights of registered medical practitioners; (vi) Professional misconduct and methods of dealing with it; (vii) Constitution and functioning of the Councils as Supervisory bodies.

In short, these Acts are directed towards controlling medical education and professional conduct of doctors. A Medical Council is required to be set up of nominated as well as elected members. Under all the Acts the tenure of the Council is 5 years. The Council is to ensure the minimum educational standards including staff, equipment, accommodation. It can recommend recognition or withdrawal of recognition of an institution. It can prescribe the courses of studies and it can conduct and supervise exams. The Council is to maintain register of all eligible practitioners and is empowered to conduct enquiry against an erring doctor and can punish the doctor even to the extent of removing his name from the register thus debarring such a doctor from practising. The Act concerning Dentists and Nurses also follows a similar pattern.

Let us look at these Acts in detail to understand their functioning. It is not practically feasible to look into all the laws of all the States. We have therefore decided to deal with the Central Legislation and the laws operating in the State of Maharashtra as sample studies. It may, however, be noted that the corresponding laws in other States are more or less of the same pattern as the Maharashtra laws. The list of Acts dealing with medical practice in India and in Maharashtra are as follows:

The Indian Medical Council Act, 1956

This Act is concerned with "modem medicine" or what in common parlance is known as Allopathic medicine. It deals with the constitution of medical council and maintenance of medical register. Under Section 2(f) "medicine" is defined to mean: "modem scientific medicine in all its branches and includes surgery and obstetrics, but does not include veterinary medicine and surgery".

Medical Council:

Medical Council is to be constituted by the Central Government consisting of the following members: (i) One member from each State, nominated by the Central Government in consultation with the State Government; (ii) One member from each University, to be elected from the medical faculty; (iii) One member from each State in which State medical register is maintained, elected from themselves by those enrolled in such register etc. (iv) 8 members to be nominated by the Central Government.

The term of office of the Council is for 5 years.

Qualifications:

The Act has three Schedules. The Schedules list out the qualifications which are recognised. First Schedule is the main Schedule. Qualifications which are listed in this Schedule and granted by any University or Medical institution in India are the recognised qualifications for the purposes of the Act, i.e. recognised for practising modem medicine. The Schedule can be amended by the Central Government at the instance of a University or Institution by including any additional qualification. Qualifications are therefore recognised University-wise. For instance, it is not enough to have a M.B.B.S. degree. It is further required to have this Degree from a recognised University and the University should not merely be recognised but it must be recognised for a particular course. Ordinarily, a University is autonomous and grants degrees for courses which it recognises. The courses may be run by private colleges affiliated to Universities. But in the sphere of medicine it is not enough for the concerned course to be recognised by the University but also by the Medical Council.

Second Schedule deals with those medical qualifications which are recognised in India though granted by Institutions outside India. Essentially these deal with countries with whom India has a scheme of reciprocity. The Council can directly enter into negotiation with the authority of a foreign country for adding to the Schedule any other qualifications but the power to finally decide lies with the Central Government. If a person obtains a medical qualification listed in this Schedule from a recognised foreign University he would be entitled to get registration and practise medicine in India without obtaining any further qualification in India, But even if a person is extremely well qualified and well reputed and even if for years s/he has

been practising medicine in a foreign country, s/he will not be allowed to practise modern medicine in India if his/her qualification does not fall within Schedule II

Schedule III deals with those medical qualifications which do not form part of first two schedules but which were granted prior to independence or soon after independence by certain institutions which presently do not form part of India but which at that time were part of larger India. This is essentially to encompass those persons who obtained medical qualifications from recognised Universities in Pakistan and Bangladesh.

The Medical qualifications mentioned in the Schedules are sufficient for enrolling a practitioner on any State Medical Register and such a person can practise medicine in any part of India.

Rights Of Registered Practitioners:

Section 15(2) of the Act is important. It reads: "(2) Save as provided in Section 25, no person other than a medical practitioner enrolled on a State Medical Register,-

(a) Shall hold office as physician or surgeon or any other office (by whatever designation called) in Government or in any institution maintained by a local authority; (b) shall practice medicine in any State; (c) shall be entitled to sign or authenticate a medical or fitness certificate required by any law to be signed or authenticated by a duly qualified medical practitioner; (d) shall be qualified to give evidence at any inquest or any court of law as an expert under section 45 of the Indian Evidence Act, 1872 on any matter relating to medicine" A person contravening this provision can be punished with imprisonment of up to I year

In short, every medical practitioner is required to be registered in a State Register. These Registers are provided for under the respective State Enactment. For any individual to practise modern medicine in any part of India two preconditions are necessary: (i) S/he must possess a qualification mentioned in one of the three Schedules listed in the Central Act; (ii) S/he must get himself registered under any of the State Acts.

Every person who is registered on the Indian Medical Register shall be entitled to, according to his qualifications, to practice as a medical practitioner in any part of India and, "to recover in due course of law in respect of such practice any expenses, charges in respect of medicaments or other appliances or any fees to which he may be entitled". (Section: 27).

Courses Of Study:

The Council is empowered to prescribe minimum standards of medical education required for granting recognised medical qualifications (other than post-graduate medical qualifications) by Universities or medical institutions in India. (S. 19 A).

As regards post graduate studies, the Council can prescribe standards of education for the guidance of the Universities and may advice Universities to have a uniform standard of post graduate studies all over India. The Central Government is empowered to constitute from amongst the members of the Councils a post-graduate medical education committee. This is essentially an advisory body.

Registration And Professional Conduct

The Council can prescribe standards of professional conduct and etiquette and a code of ethics for medical practitioners. The regulations may provide as to which violation shall constitute infamous conduct i.e. professional misconduct. (S. 20 A).

The Council is to maintain Indian Medical Register containing names of all those who are for the first time being enrolled on any State Medical Register and who possess any of the recognised medical qualifications. If the name of a person is removed from the State Medical List pursuant to the exercise of a valid power, the Central Council shall direct his/her name to be removed also from the Central list. If a practitioner's name is removed from the State list on grounds of professional misconduct, s/he can appeal to the Central Government, who will decide the appeal in consultation with the Central Council and the decision of the Central Government will be binding on the State Council and the authorities maintaining the State list. (S.24).

1. Every University and medical institution which grants a recognised medical qualification can be asked to furnish details by the Council regarding the Course of Study and Examinations.

2. Inspectors and Visitors can be appointed by the Council to personally visit a University or institution to inspect and such institution and attend any exam. This is for the purpose of recommending to the Central Government the recognition of any medical qualification granted by such University or Institution. The Inspectors and Visitors are also required to report to the Council regarding the adequacy of standard of education including staff, equipment, accommodation, training and other facilities.

If upon the report, the Council believes that the standards of medical education are not being properly maintained, it can make a representation to that effect to the Central Government. The Central Government may send it to the concerned State Government which in turn will send it with its own remarks to the institution concerned, with the requirement to show cause within a specified period.

Indian Medical Council Rules, 1957

The election to the Council has to be by postal ballot. Rules for election are virtually identical to those prescribed under the Maharashtra Rules which are detailed subsequently. The only difference is that the electors are to send their votes only by

registered post. An Appeal in respect of the elections lies not to the State Government as under the State Acts but to the Central Government.

The Maharashtra Medical Council Act, 1955

This is the corresponding State law concerning modern medicine. Section 2(d) defines medical practitioners to whom the Act is to be made applicable. It reads: "'medical practitioner' or 'practitioner' means a person who is engaged in the practice of modern scientific medicine in any of its branches including surgery and obstetrics, but not including veterinary medicine or surgery or the *Ayurvedic*, *Unani*, Homeopathic or Biochemic system of medicine. "

Council

State Government is to constitute Maharashtra Medical Council having the following members:

"The Director of Health services, ex officio, (ii) The Director of Medical Education and Research, ex officio, (iii) 5 members to be nominated by the State Government of whom at least 4 are practitiioners; (iv) I member each to be elected by every University in the State which has a medical faculty. The election to be by the members of the faculty from those who are practitioners, (v) I member to be elected by the College of Physicians and Surgeons, Bombay from amongst members who are practitioners; (vi) 9 members to be elected by registered members from amongst themselves.

The term of office of the members has to be five years.

The powers, duties and functions of the Council are as follows:

(i) To maintain the register and to provide for the registration of the medical practitioners.
(ii) To prescribe a code of ethics for regulating professional conduct of practitioners.
(iii) to exercise disciplinary control over practitioners.

Registration

Those practitioners who have the qualifications prescribed in the Schedule to the Act or any of the qualifications listed in any of the Schedules to the Indian Medical Council Act, can get himself registered. A person whose name has been removed from any of the registers under any law requiring registration of medical practitioners on grounds of misconduct will be liable to have his/her name deleted even from the register maintained under this Act.

If the Council, after a due enquiry finds a registered practitioner guilty of misconduct, s/he may be warned, suspended or his/her name may be removed from the register. Misconduct means the following:

(i) Conviction by a criminal court for an offence involving moral turpitude; (ii) conviction under the Army Act, 1950; (iii) any conduct, which in the opinion of the Council is infamous in relation to the medical profession particularly under any code of ethics presented by the council or by the Medical Council of India under the Indian Medical Council Act, 1956. While holding enquiry, the powers of the Council are the same as of a civil court including the following powers: (a) enforcing the attendance of any person and examining hinder on oath; (ii) compelling the production of documents; (iii) issuing of commissions for examination of witnesses.

Maharashtra Medical Council Rules, 1967

The Rules deal with the following three aspects:

(i) Elections to the Medical Council;
(ii) Functioning of Medical Council;
(iii) Procedure for enquiries and punishment of medical practitioners.

A major section of the Rules deal with the procedure for elections of medical practitioners. Nine members on the Council are to be elected from the registered practitioners and hence the elections and their procedure acquire tremendous importance. Following is the broad procedure for elections:

(1) The Registrar is the Returning Officer. (2) He is to fix, the date, place and time for a. receipt of nomination papers; b. scrutiny of nomination papers; c. withdrawal of candidature; d. receipt of ballot papers; and e. counting of votes. (3) The Registrar is to prepare the electoral rolls of all registered practitioners; (4) The Roll has to be kept open for inspection in the Council 30 days prior to the last date for receipt of nomination papers, (5) The Registrar has to issue a Notice in the Official Gazette and advertise in four newspapers calling upon the registered practitioners to send their objections or suggestions with regard to entries in the electoral roll before a date specified in the Gazette and corrections are to be made by the Registrar in the Rolls if the objections are found to be correct. If a practitioner is aggrieved by the decision he may prefer an Appeal against such order to the State Government; (6) Every registered practitioner will be qualified for nomination as a candidate. For contesting elections, they have to be proposed and seconded by registered practitioners. The nomination has to be in the prescribed format which is to be supplied by the Registrar. Nomination papers received after the time fixed would be disallowed. As soon as the nomination paper is received the Returning Officer is to record the time and date of the receipt of nomination. (7) Scrutiny of the nomination papers have to be done at the time and place fixed by the Registrar and at the time of scrutiny the nominee as well as the proposer and the seconder can remain present. Those present

are to be given sufficient opportunity to examine the nomination papers and raise their objections which are to be dealt with by the Registrar. The nomination papers can be rejected for reasons such as: a. the Candidate or his proposer or seconder are not electors; b. that there has been any failure to comply with the provisions of the Act or the Rules concerning elections to the council; c. Signature of the candidate or his Proposer or Seconder is not genuine or has been obtained by fraud. (8) The Registrar is to record on each nomination papers whether it is accepted or rejected and if rejected then the reasons for the same. The scrutiny has to be complete on that very day and cannot be adjourned. (9) On the Notice of the Council as well as in the Gazettethe list of eligible candidates has to be displayed. (10) The voting has to be by postal ballot. (11) The ballot papers are to be printed and 21 days before the last date for receipt of ballot papers the Registrar has to send to every elector by post under certificate of posting, a. one ballot paper signed by him; b. a smaller blank cover with the words 'ballot paper' printed on it; c. A larger cover addressed to himself, i.e. the Registrar. (12) On the electoral roll, the Registrar shall make a mark against the name of every elector to whom the copy of the ballot paper and cover has been sent. The marked copy of the electoral roll and the counterfoils of the ballot papers shall be sealed in a packet after the date fixed for receipt of ballot papers. (13) The elector can vote for as many candidates as there are vacancies and can give only one vote to each candidate. The elector is not to reveal his identity by any means on the ballot paper. The ballot paper is to be than put in the smaller cover, selaed and than put in the larger cover. On the larger cover, the elector has to write his name and sign. The larger cover is than to be sent to the Registrar by 'post or otherwise'. (14) The ballot papers are to be kept in a sealed box by the Registrar after noting the date and time of their receipt. (15) The counting of votes will be on the date and time fixed by the Registrar. The candidate and one more person authorised by him can remain present at the time of counting of votes. (16) The ballot paper shall be treated as invalid if, a. the elector has not written his/her full name or signed on the large cover; b. If the cross mark is made against more number of candidates that the vacancies to be filled; c. If the elector has made any mark on the ballot paper which can reveal his identity. (17) Once the counting is over, the Registrar will immediately declare the results. After the election, the ballot papers and covers are to be sealed and retained by the Registrar for six months. Any election dispute can be referred to the State Government within 30 days of declaration of results.

Functioning Of The Council

(I) Council is to meet twice in a year - in February and September. But it can also be convened by the President or by a move supported by at least seven members.

(MISSING PAGE: Between Page 60 and 61, original draft)

the medical practitioner of the charges levelled against him if the explanation offered by him is considered satisfactory by the Council; (iv) Direct a regular enquiry to be held.

Enquiry: (i) An enquiry is not necessary if the practitioner has been convicted by a criminal court of an offence involving moral turpitude, or if he is convicted under the Army Act, 1950 for a cognisable offence. In such cases the President shall place before the Council a copy of the Judgement and the Council will thereupon decide the punishment to be imposed. (ii) A notice will be served upon the charged practitioner with all the details of the offence with which the practitioner is charged. The Practitioner is to be asked to furnish his written statement. The notice is to be accompanied by a Statement of allegations. Copies of the relevant documents is to be supplied by the Council to the practitioner. If the Complainant makes a written request, he is also to be given the documents, (iii) At the enquiry, the Council may be assisted by a legal practitioner. Similarly, even the complainant and the Practitioner are also entitled to be represented by a legal practitioner. In addition to this, the Council may appoint an Assesor who has to be an Advocate to advice it in the matters of law. (iv) At the enquiry, first the Complainant leads the evidence and any witnesses and thereafter the practitioner is to lead his evidence and witnesses. The members of the Council and the Assesor can put questions to the witnesses (v) After the hearing, the Council is to deliberate and announce the majority verdict

Indian Medicine Central Council Act, 1970

This law deals with the systems of Indian Medicine, namely, *Ayurvedic*, *Unani* and Siddha branches of medicine. It is a Central Legislation applicable all over India for providing a Central Council and a Central Register of Indian Medicine. The basic object of the Act is to lay down the qualifications which permit individuals to practice Indian Medicine and which can be awarded by Universities for such a practice. All those who are permitted to practice Indian Medicine have to be on the Central Register maintained by the Indian Council and the Central Council is set up as the overall supervisory body to implement these objects and to also to maintain control over unethical practices of the doctors practising Indian medicine.

As stated above it only applies to Indian Systems of Medicine. Indian Medicine' has been defined under Section 2(1) (e) as: "Indian Medicine means the system of Indian Medicine commonly known as Ashtang Ayurveda, Siddha or *Unani* Tibb, whether supplemented or not by such modern advances as the Central Council may declare by notification from time to time"

Central Council

The Central Council is to consist broadly of the following members:

I member each from every University elected by the members of the concerned Department or Faculty (ii) Not more than 5 elected members from each State from the State Register, (iii) Not more than 30% of (i)+(ii) nominated by the Central Government being persons who have special knowledge on the subject.

The President of the Council has to be elected by the members of the Council and there are to be three Vice Presidents - one from each system elected by the Council members belonging to that system.

The elections to the Council are to be held once in every five years.

The Council is to meet once a year with 1/3 members being the quorum but with at least three members from each of the three branches. The Central Council has also to constitute three committees - one each for each of the three systems and the Vice President of the Council for the respective system is to be the Chairperson of the Committee. The Committees are also to meet once a year.

Qualifications

Sections 14 to 16 deal with qualifications. The Act has various Schedules. Schedules 2, 3 and 4 list various qualifications. Section 14 states that qualifications listed in the 2nd Schedule given by any University, Medical Institution or Medical Board in India are the recognised qualifications for practising Indian Medicine. Section 15 deals with those qualifications which
were given in those parts of India which were parts of undivided India prior to 1947. If these qualifications were received prior to 1947 and are listed in the 3rd Schedule, then they are also recognised qualifications for practising Indian Medicine in India. Section 16 deals with those qualifications which are obtained outside India but are recognised qualifications for practising Indian Medicine in India. These qualifications are listed in the 4th Schedule to the Act. These
are the qualifications from Universities in countries with which India has a scheme of reciprocity. Central Council has also been given powers to directly negotiate with any of the countries for arriving at a scheme of reciprocity.

Rights

Section 17 provides the rights of persons having the qualifications listed in 2nd, 3rd and 4th Schedule. It provides for the following:

(a) If a person is in possession of any of the qualifications listed in Schedules 2nd , 3rd or 4th, s/he will be entitled to be enrolled in the State Register.

(b) Unless a person is enrolled in the Central or State Register, (i) s/he shall not hold post of Vaid, Siddha, Hakim or any other office in Government or any other institution maintained by local or other authority; (ii) practise Indian Medicine in any State in India; (iii) s/he shall not be entitited to sign or authenticate a medical or fitness certificate required by law to be signed by a medical practitioner; (iv) s/he shall not give any expert evidence in a court of law.

The Act however makes it clear that if on the commencement of the Act such a person was practising Indian medicine without having the required qualifications, s/he can be allowed to continue to practise. If a person not having the prescribed qualifications is found to be doing any of the things mentioned above, on conviction s/he is liable to maximum imprisonment of I year
or fine of Rs. l,000/- or both. The conviction contemplated has to be by a criminal court and not by the Central Council.

Inspection

In order to exercise the power of supervision and for other purposes, the Central Council has been given the powers to call for information from Universities.

Under Section 19, for the purposes of recognising a qualification, the Central Council has to appoint Inspectors with the right to visit colleges, hospitals, etc. or even attend during the time of exams. The Inspectors are to give reports to the Councils about the standards, equipment, training, etc. imparted in the given course. The Council in turn is required to submit the Report to the University concerned and to the Government.

For the same objects as above, the Council can also appoint visitors who can personally visit various institutions and make their report. These Reports constitute the basis of a decision to grant or cancel a qualification. On the basis of the Reports the Council has to make a report to the Central Government. The Central Government in turn would forward the report to the concerned State Government which is required to forward it to the University asking for its explanation regarding the proposed action. Upon receiving the explanation, the State Government is to make the necessary recommendation to the Central Government which thereafter decides the course of action. If the Central Government decides to recognise a particular qualification or withdraw the recognition already granted it has to amend the Schedule to the Act accordingly.

Education

Section 23 empowers the Central Council to prescribe minimum standards of education for Indian Medicine. The Council has to submit its recommendations to the State Governments and thereafter to seek the approval of the Central Government.

Central Register

Central Council is required to maintain separate registers for each system of medicine and in this register the names of the qualified practitioners of the respective systems of medicine have to be enrolled. Each Board is required to submit its own list to the Central Council every year.

Ethics

The Central Council is to prescribe the standards of professional conduct and etiquette and code of ethics. It is also required to prescribe as to which violation will involve infamous conduct in professional respect.

Removal Of Name

If the name of a medical practitioner is removed from the State Register, s/he can Appeal to the Central Government if the name is removed due to want of qualifications. Central Government is to consult the Central Council.

The Maharashtra Medical Practitioners Act, 1961

This law was enacted to regulate the qualifications and to provide for the registration of practitioners of the *Ayurvedic*, Siddha and *Unani* systems of medicine with a view to encourage the study and spread of such systems, etc. It is therefore the state act for the constitution of state medical council for the Indian systems of medicine.

Under this Act, "Indiam Medicine' means the system of Indian Medicine commonly known as Ashtang *Ayurvedic* or Siddha or *Unani* or *Unani* Tibb, whether supplemented or not by such modern advances as the Central Council from time to time by notification may declare", under the Indian Medicine Central Council Act, 1970. (S.2 (fa)).

Council

'Maharashtra Council of Indian Medicine' is constituted under the Act. It is to consist of the following members:

Director of Ayurved, ex-officio, (ii) 5 members nominated by the State Government of whom 2 practitioners in Ashtang Ayurved or Siddha system of medicine and 2 practitioners in *Unani* or *Unani* Tibb system; (iii) 9 members elected by registered practitioners out of which (a) 5 by registered practitioners whose names are entered in Part I of the Register; (b) 4 elected by registered practitioners whose names are entered in Part II of the Register; (iv) 2 members elected by Heads or Principals of recognised institutions from amongst themselves; (v) 2 members elected by teachers (other than principles or Heads) of recognised institutions from amongst themselves; who are registered practitioners possessing qualifications prescribed in the Schedule

The President and Vice President of the Council shall be elected by members from amongst themselves. The term office of the members hall be 5 years.

Functions And Duties Of Council

To provide for registration of practitioners and maintain the register; (II) To prescribe a code of ethics for professional conduct; (III) To take disciplinary action against practitioners. (IV) To hold examinations. (V) To prescribe courses for training and to

grant Degrees or Diplomas. (VI) To recognise institutions for training. (VII) To provide for post graduate training. (VIII) To recommend the inclusion or deletion of any Degree, Diploma or Certificate from the Schedule. (IX) To provide for inspection of recognised institutions.

Registration

Register of practitioners has to be maintained. The Register is to be in three parts but essentially speaking it is to consist of those medical practitioners who have the qualifications prescribed in the Scheduled. A practitioner who is enrolled on the register maintained under the Indian Medicine Central Council Act, 1970 but not enrolled under this Register has a right to apply for
such registration and be registered. (S. 17).

Misconduct

If after a due enquiry, the Council finds a member guilty of misconduct, he can be warned, suspended or permanently removed. Misconduct includes the following:

(i) Conviction by a court of a criminal offence involving moral turpitude;
(ii) Any conduct, which in the opinion of the Council is infamous in relation to the medical profession particularly under any Code of Ethics prescribed by the Board.

If a practitioner is also registered under the Homeopathic or Modern Medicine Act and if his/her name is removed from such register for misconduct then his/her name shall also be removed from the Register under this Act.

In holding an enquiry under this Act, the Council shall have the power vested in civil courts under the Code of Civil Procedure including the power to: (i) to enforce the attendance of any person and examining him/her on oath; (ii) compelling the production of any document, (iii) issuing commissions for the examination of any witnesses.

A practitioner registered under this Act is entitled to issue medical certificates and shall be also entitled to perform all such functions as are permissible to be done by 'medical practitioners' under any laws within Maharashtra.

The Council is to provide for the examinations, courses of studies (including in the subjects of medicine, midwifery, surgery and gynaecology), qualification, standards of passing, etc. Institutions recognised under the Act will be entitled to train students for such examinations. An institution desirous of recognition has to make an application to the Council and the Council has to ensure adequacy of equipment, accommodation, strength of staff. Local enquiry has to be conducted by the Council and the Report of the enquiry along with its recommendations shall be submitted by the Council to the State Government along with its recommendations. It is for the State Government to grant or refuse recognition. It is however, the duty of the

Council to secure the maintenance of an adequate standard of proficiency in the subjects of medicine, surgery, midwifery and Gynaecology and for the practise of *Ayurvedic* and *Unani* system of medicine. For such maintenance, the Council will have the right to call for reports and information as also to inspect premises including hospitals as also to be present during the examinations. Reports of such inspection will be made to the State Government. If despite instruction an institution does not come up to the mark, the State Government can withdraw recognition. (Ss. 26 to 28).

Medical practice for this Section is defined under S.2(2) of the Act as, "a person shall be deemed to practise any system of medicine who holds himself out as being able to diagnose, treat, operate, or prescribe medicine or other remedy or to give medicine for any ailment, disease, injury, pain, deformity or physical condition or who, by any advertisement, demonstration, teaching or exhibition offers or undertakes by any means or method whatsoever to diagnose, treat, operate or prescribe medicine or other remedy or to give medicine for any ailment, disease, injury, pain, deformity or physical condition: provided that a person who - (i) mechanically fits or sells lenses, artificial eyes, limbs or other apparatus or appliances; or (ii) is engaged in the mechanical examination of eyes for the purpose of construction or adjusting spectacles, eye glasses or lens; or (iii) practises physiotherapy or electro-therapy or chiripody or naturopathy or hydro-pathy or yogic healing; or (iv) without personal gain furnishes medical treatment or does domestic administration of family remedies; or (v) being registered under the Dentists Act, 1948, limits his practise to the art of dentistry; or (vi) being a nurse, midwife or health visitor registered or enlisted under the Bombay Nurses, Midwives and Health Visitors Act, 1954, or any other corresponding law for the time being in force in the State or a Dai attends on a case of labour, shall not be deemed to practice medicine".

No person who is not a registered practitioner under any of the Acts referred to above, shall hold any appointment as - (a) physician, surgeon or other medical officer in any hospital, infirmary or dispensary not supported wholly by voluntary contribution; (b) medical officer of health of any local authority; (c) teacher in medicine, surgery or midwifery in any public institution. A contravention can lead to fine up to Rs.500/- (Section 33A). A medical certificate required to be signed by a doctor will be valid only if signed by a person registered under any of the aforesaid Acts.

Section 36 reads: "(1) No person shall add to his name any title, description, letters or abbreviations which imply that he holds a degree, diploma, license or certificate or any other like award as his qualification to practise any system of medicine unless- (a) he actually holds such a degree, diploma, license or certificate or any other like award; (b) such degree, diploma, license or certificate or any other like award- (i) is recognised by any law for the time being in force in India or any part thereof, or (ii) has been conferred, granted or issued by a body or institution referred to in sub-section (1) of section 35, or (iii) has been recognised by the medical council of India, or (iv) has been recognised by the Central Council of Indian Medicine." First contravention can lead to fine of Rs.500/- and subsequent contravention can lead to imprisonment of up to 6 months.

Clearly, the definition of "medical practice" given under this act is very broad and transcends the definition of Indian Systems of Medicine given in the central act. In fact, this act has been often criticised for providing loopholes to the cross-system practice, a limited protection to doctors not holding proper degrees etc. Few court judgements in recent times tried to curb the cross system practices by doctors. However, the protests by a section of doctors made the state government to amend the act in November 1992. Accordingly, the doctors holding degrees mentioned in parts A, B and A-1 of the schedule to the act were granted permission to practice allopathic medicine "to the extent of the training they received in that system."

The code of medical ethics prescribed under this act for the practitioners of Indian systems of medicine basically incorporates some of the elements of the code for the practitioners of the modern systems of medicine. However, unlike the code for the modern system of medicine, this code is less elaborate. In fact it is not formulated as a complete code of ethics consistent with the norms of the systems of medicine and flowing from the historical philosophical principles underlying the practice of the systems of medicine. Its emphasis is very practical, namely to make practitioners aware that there are conducts which could invite penalties under the act. Thus, it opens with the clause of the act which provides for the removal of name from the register and goes no to list or explain: (a) Some objectionable practices, (b) Issuing of medical certificates, (c) medical attendance and consultation, (d) general matters and lastly (e) miscellaneous matters.

The Rules under the aforesaid Act are virtually identical as those provided under the Maharashtra Medical Council Rules. However, instead of being incorporated within one set of Rules, they are split up into separate Rules as follows:

(i) Maharashtra Council of Indian Medicine Rules, 1961; (ii) Maharashtra Medical Practitioners (Registration) Rules, 1961, (iii) The Maharashtra Medical Practitioners (Publication of Medical List) Rules, 1966; (iv) Maharashtra Council of Indian Medicine (Election) Rules, 1967; (v) The Maharashtra Medical Practitioners (Enquiry into Misconduct) Rules, 1967.

Homeopathy Central Council Act,1973

In 1968 a Bill was presented in the Rajya Sabha for a composite Council for Indian Medicine and Homeopathy. But the Parliamentary Committee decided to separate the two and hence this separate Enactment was passed for Homeopathy. It follows the same pattern as the other Central Acts

The object is to evolve a uniform standard of education in Homeopathy and for registration of Homeopaths

Homeopathy is defined to mean the Homeopathic system of medicine and includes the use of biochemic remedies.

A Central Council of Homeopathy is set up under the Act having the following members:

(i) 5 or less than 5 elected Homeopaths from each State; (ii) I Homeopath elected from each University; (iii) 40% or less nominees of the Central Government having special knowledge or practical experience in Homeopathy or other related disciplines.

The term of office is to be five years.

Qualifications mentioned in the second Schedule are the recognised qualifications and those in the IIIrd Schedule are recognised qualifications as granted by foreign Universities. Any institution or authority which grants a Homeopathic qualification not prescribed in IInd Schedule can apply to the Central Government for having it included in that Schedule and the Government may, after consulting the Council and upon enquiry include it in Schedule II. Any person who has the qualification mentioned in Schedule II or III will be eligible to be registered in the State Homeopathic Register.

No person other than a person enrolled on a State or Central Register can- (i) Hold office of Homeopathic Physician or any other office in the Government or local or other authority; (ii) shall practise Homeopathy; (iii) Give any Medical or fitness Certificate; (iv) Give evidence as an expert Upon conviction for violating this provision, a person can be sentenced to I year's imprisonment or Rs. 1000/- fine or both.

The Council will have the right to get information concerning the courses of study and the examination conducted by any Authority or University. The E'C. can appoint inspectors to inspect any institution during the examination or otherwise. The Council can also appoint Visitors for this purpose. If the Council is satisfied that an institution does not satisfy the requirement of infrastructure or other regulations, it may recommend its de-recognition to the Central Government. The Central Government, after taking into consideration the stand of the State Government may de-recognise such course.

The Central Council is to prescribe the minimum standard of education to be followed by all institutions granting recognised qualifications. The Council can prescribe the standards of professional conduct or etiquette or code of ethics for Homeopaths. The Council shall maintain an Indian Registrar of Homeopaths consisting of all names appearing in the State Registers and the Board will supply each year to the Council the State lists. Every person who is registered
under the Act, can in accordance with his qualification, practice Homeopathy in any part in India.

The Bombay Homeopathic Practitioners' Act, 1959

This law is passed with a view to regulate the law relating to qualifications and registration of Homeopathic practitioners in Maharashtra. It came into force from 27th October, 1961.

'Homeopathic Medicine' is defined under Section 2(8) to mean "the Homeopathic system of medicine and includes the use of biochemic remedies".

Council

Maharashtra Council has been set up which is to include the following:

(i) The Deputy Director of Homeopathy, ex officio, (ii) 4 persons nominated by the State Government having special knowledge or practical knowledge of Homeopathy; (iii) 3 members elected by registered Homeopathic Practitioners from amongst themselves; (iv) I member elected by the principals or heads of recognised Homeopathic institutions from amongst themselves, (v) 2 members elected by teachers (other than heads/principals) from recognised homeopathic institutions from amongst themselves.

The President and Vice President are to be elected members from the Council. The term of office is to be five years.

The powers and duties of the Council are as follows:

(i) to provide registration for members and to maintain a register; (ii) to decide appeals from any decision of the Registrar; (iii) to take disciplinary action against a registered member including suspension and removal; (iv) to hold examinations; (v) to conduct courses of training leading to the examinations; (vi) to grant degrees and diplomas; (vii) to recommend recognition or cancellation of an institution; (viii) to prepare and prescribe text books; (ix) to provide for adequate standard of proficiency for the practice of homeopathic medicine; (x) to provide for recognition of institutions training in homeopathic medicine.

After consulting the Council the State Government is to appoint a registrar.

Registration Of Practitioners

The Registrar is to prepare and maintain a register of Homeopathic practitioners for Maharashtra. A registered practitioner is to be given a registration certificate and is entitled to practice Homeopathy only.

A registered practitioner will have the following rights:

(a) S/he will be entitled to all the rights and powers which a registered medical practitioner gets under any State law or Central law as applicable to Maharashtra; (b) S/he will be entitled to sign medical certificates; (c) S/he will be entitled to the post of

a Physician or medical officer in a State owned or aided institution which is treating patients with Homeopathic treatment.

Recognition Of Institutions

A Homeopathic educational institution has to be recognised by the Council. Such recognition can be granted only if the institution meets the requirement of the Council regarding accommodation, equipment, staff and other facilities. A local enquiry committee is to be constituted by the Council which ensures the compliance with all the requirements and only then recognition is granted. The Council is responsible for adequate standard of proficiency and towards this it can continuously monitor the institution and the examinations through inspectors. The Council, in fit cases, can make a recommendatory report to the State Government and the State Government can withdraw the recognition granted to an institution. Prior to this, of course, the institution has to be given adequate opportunity of being heard and also for reasonable time to come up to standards required of it by the Council.

Even under the Homeopathic Act, the Rules follow the same pattern as under the Allopathic Act. These provisions are contained in the following Rules:

(i) Homeopathic and Biochemic Practitioners' Rules, 1961; (ii) Board & Court of Examiners of Homeopathic & Biochemic Systems of Medicine (Election) Rules, 1961.

Indian Medical Degrees Act,1916

This Act is directed towards assumption of titles by individuals which imply qualifications in western medical sciences. 'Western medical science' is defined to mean western method of allopathic medicine. Obstetrics and Surgery, but does not include the Indian, Homeopathic or *Ayurvedic* systems of medicine.

The right of granting degrees, diplomas, licenses or certifactes staling or implying that the holder is entitled to practice western medicine is only with the following authorities;

(i) Universities established by a Central Act;
(ii) The College of Physicians and Surgeons, Bombay.

If any other person grants such degree, etc. s/he shall be fined Rs. 1000/- and if it is conferred by an association, every member can be fined up to RS.SOO/-. No person should add to his/her name any title, description, letters or abbreviations which implies that s/he holds a degree, diploma, license or certificate as his/her qualification to practice any system of medicine unless - (i) s/he actually holds such degree, diploma, license or certificate and (ii) such degree, diploma, license or certificate is recognised in India and has been granted by an authority referred to above. A person breaching this provision can be fined Rs.250/-.

The Dentists Act, 1948

Unlike in respect of other Acts relating to medical practice, on the subject of Dentistry there are no State Laws. The practise of Dentistry is governed all over India by the Dentist Act, 1948.

There are three categories of practitioners recognised under the Act.

'Dentist' is defined as a person who practises Dentistry, (ii) 'Dental Hygienist' means a person not being a dentist or a medical practitioner, who scales, cleans or polishes teeth or gives instructions in Dental hygiene, (iii) 'Dental Mechanic' means a person who makes or repairs denture and dental appliances.

As stated above. Dentist is one who practises Dentistry. Dentistry is defined as under:

"Dentistry includes- (i) the performance of any operation on, and the treatment on any disease, deficiency or lesion of, human teeth or jaws, and the performance of radiographic work in connection with human teeth or jaws or the oral cavity, (ii) the giving of any anaesthetic in connection with any such operation or treatment, (iii) the mechanical construction or the renewal of artificial dentures or restorative dental appliance, (iv) the performance of any operation on, or the giving of any treatment, advice or attendance to, any person preparatory to, or for the purpose of, or in connection with the fitting, inserting, fixing, constructing, repairing or renewing of artificial dentures or restorative dental appliances, and the performance of any such operation and the giving of any such treatment advice or attendance as is usually performed or given by dentists"

The Central Government constitutes a Council consisting of the following members:

One person from amongst the registered practitioners registered in Part A of each State Register; (ii) One member from amongst themselves by members of Medical Council of India, (iii) Not more than four members elected from Dental Academic Institutions, (iv) One elected member from each University; (v) One person nominated by each State from amongst registered medical practitioners or dentists; (vi) Six members to be nominated by the Central Government; (vii) Director General of Health Services, ex officio.

The term of the Council is to be five years

Dental Qualifications

1. Dental qualifications granted by any Authority or Institution in India which are listed in Part I of the Schedule will be recognised qualifications 2. Any institution or authority which grants a dental qualification not prescribed in Part I can apply to the Central Government for having it included in Part I and the Government may, after

consulting the Council and upon enquiry include it in Part 1. 3. Part II and III deal with recognition of qualifications granted by institutions outside India.

Dental Education

No one can without the permission of the Central Government-

(i) Establish an authority or institution for a course of study or training (including post graduation) which would enable a student of such course qualify him/herself for the grant of dental qualification; (ii) No institution or authority conducting a study for grant of recognised dental qualification shall- (a) open a new or higher course of study without the permission of the Central Government; (b) increase its admission capacity in any course without the permission of the Central Government. The Admission capacity has to be fixed by the Council.

Dental Hygienists

Any authority in a State which grants qualifications for Dental Hygienists can apply to the Council for having the same recognised. Council can also prescribe the period or an apprenticeship which, shall be undergone and the other conditions which have to be satisfied before s/he can be registered as a Dental Mechanic. Only a person who has the recognised qualification can be enrolled in the appropriate register of a State.

The Council will have the right to get information concerning the courses of study and the examination conducted by any Authority. The EC can appoint inspectors to inspect any institution during the examination or otherwise. The Council can also appoint Visitors for this purpose. If the Council is satisfied that an institution does not satisfy the requirement of infrastructure or other regulations it may recommend its de-recognition to the Central Government. The Central Government, after taking into consideration the stand of the State Government may de-recognise such course.

The Council can prescribe the standards of professional conduct or etiquette or code of ethics for dentists. The Council shall maintain an Indian Registrar of Dentists consisting of all names appearing in the State Registers.

Each State Government is to constitute a State Dental Council consisting of 8 dentists elected from themselves, heads of dental colleges, and three nominated members by the State Government. If two or more States enter into an agreement. Joint State Councils can be constituted. The term of office of the members shall be five years. The State Council shall maintain a State Register containing the names of the registered dentists. A person who holds a recognised dental qualification and domiciled in the State can apply to the Registrar for being registered. If his/her application is rejected, than within 3 months s/he can appeal to the State Council. The State Council will similarly maintain a register of Dental Hygienists and Dental Mechanists. As stated earlier, no state or joint state dental councils have been formed by passing appropriate laws.

Removal of name from the register

The name of any of the aforesaid persons can be removed from the register if-

(i) his/her name has been entered due to error or misrepresentation; (ii) s/he has been convicted of any offence or has been guilty of any infamous conduct in professional respect or has violated the standards of professional conduct and etiquette or the code of ethics which in the opinion of the State Council renders him unfit for being retained on the register. The Council may further order whether such person's name has to be removed permanently or for a limited period. The aggrieved person can appeal to the State Government within 30 days.

No Certificate required under any law to be signed by a Dentist shall be valid unless signed by a Dentist registered under this Act. A person registered under this Act can practise in any State in India. If a person who is not registered, uses such a title, s/he can be fined on first conviction with fine of Rs.500 and with subsequent convictions with imprisonment up to six months or with fine of Rs. l,000 or with both. No person who is not registered as a dentist, dental hygienist or dental mechanic can practise the said professions. But this will not apply to- (a) any registered medical practitioner, or (b) the extraction of tooth by any person when the case is urgent and no registered practitioner is available, so however, the operation is performed without any general or local anaesthetic, or (c) the performance of any dental work or radiographic work in any hospital or dispensary maintained or supported by public or local funds.

If a person contravenes this provision, s/he can be fined on first conviction with fine of Rs.500 and with subsequent convictions with imprisonment up to six months or with fine of Rs. l000 or with both.

The profession of dentistry will not be carried on by a company or other corporate body. But this shall not apply to a (a) Company which carries on only the business of dentistry or some business ancillary to the profession of dentistry and whose majority directors and all operating staff are registered dentists, (b) the carrying on of the profession of dentistry by employers who provide dental treatment for their employees by registered dentists otherwise than for profit.

If a person contravenes this provision, s/he can be fined on first conviction with fine of Rs.500 and with subsequent convictions with imprisonment up to six months or with fine of Rs. l000 or with both. Cognisance of any offence under this Act will not be taken by any Court except upon a complaint made under the order by State Government or by State Council.

Nursing Council Act, 1947

The Act has been passed with a view to provide for uniform standard of training for nurses, midwives and health visitors.

A Central Nursing Council has to be set up consisting of the following members:

(i) One registered nurse elected from each State Council; (ii) Two elected heads of institutions providing qualified training to nurses; (iii) One person elected by Medical Council of India; (iv) One person elected by the Central Council of Indian Medical Association, (v) One person elected by the Council of Trained Nurses Association; (vi) One midwife or auxiliary nurse midwife enrolled in State Register from four groups of States i.e. totally four such midwives or auxiliary nurse midwives; (vii) Director General of Health Services, (viii) Chief Principal Matron, Medical Director, Head; (ix) Chief Nursing Superintendent; (x) Director of Maternity & Child Welfare, Red Cross; (xi) Chief Administrative Medical Officer of each State; (xii) Superintendent of Nursing Serices; (xiii) Four nominees of Central Government out of whom at least two registered nurses; (xiv) Three elected representatives of Parliament- two by House of people and one by Council of Ministers.

The term of office shall be five years.

Part I of the Schedule to the Act deals with those qualifications which are the recognised qualifications. Part II deals with the recognition of Higher Qualifications.

Recognition of qualifications and withdrawal of qualifications is directly done by the Council and does not require the concurrence of the Central Government. Similarly negotiations and finalisation with foreign institutions and universities for recognition of qualifications can also be done directly by the Council and does not require any approval of the Government.

The Council can call for information regarding courses of study and examinations from any university and authority.

If a person has the recognised qualifications, it would be sufficient to have her/him enrolled on the State Register. There is also an Indian Nurses Register, which is an aggregate of various state registers.

The Maharashtra Nurses Act, 1966

The Act was framed to unify and make better provision for law regulating registration and training of nurses in Maharashtra. Section 2(k) defines a nurse to include male nurse, auxiliary nurse, public health nurse, midwife, auxiliary nurse midwife and health visitor.

Under the Act, the State Government constitutes Maharashtra Nursing Council. It is to consist of three ex officio members- (i) Director of Health Services; (ii) Director of Medical Education and Research; (iii) Superintendent of Nursing Services, Government of Maharashtra.

The elected members are to be as follows:

(i) One member from each of the 5 regions to be elected by registered nurses from themselves; (ii) 2 members elected by heads of affiliated institutions from themselves, (iii) 5 members from matrons of affiliated institutions from themselves; (iv) 2 members elected from themselves by sister tutors of affiliated institutions and Heads of Nursing Colleges recognised by the Council;
(v) I member elected by the Maharashtra Medical Council from amongst themselves, (vi) I member elected from the coordination committee of the local branches of the State of the Indian Medical Association; (vii) I member elected by members of faculties of Nursing, from the Universities, (viii) I member to be elected by the State branch of Indian Red Cross Society, (ix) 4 members to be nominated by the State Government. At least 3 of these must be nurses, medical practitioners or teachers in Nursing Colleges.

The term of office has to be for five years.

Powers And Duties Of Council

1. To maintain register and list for registration of nurses. 2. To prescribe code of ethics for nurses. 3. To take disciplinary action against nurses. 4. To hold examinations. 5. To prescribe courses for training and to grant certificates or Diplomas. 6. To recognise institutions for training. 7. To regulate the conditions under which institutions for the nursing of the sick, maternity or child welfare may be affiliated to the Council. 8. To provide for inspection of recognised and affiliated institutions.

Register Of Nurses

The Registrar is to maintain five registers- one for each region. A person who has undergone the prescribed training or who possesses the prescribed qualifications as provided under the Indian Nursing Council Act, 1947 is entitled to registration under this Act. A person who is not registered as Nurse cannot practise habitually or for personal gain as a Nurse. If a person does practise as Nurse without registration, for the first offence can be fined Rs. 100 and Rs. 200 for second offence and Rs. 300 for third offence onwards. The fine has to be imposed by a Magistrate of a criminal court. The Registration List has to be published every 5 years and addendum and corrigendum to the list have to be published every year in the manner prescribed under the Maharashtra Nurses (Preparation of List) Rules, 1970.

The Council has the power to prescribe conditions for recognition of training institutions. If upon inspection it is found that the conditions are violated, the recognition can be withdrawn. No school, hospital or other institution which is not recognised can issue to any person a certificate or enter the name of a person on any document purporting to show that such a person is a qualified nurse.

Nurses Establishment

A Nurses Establishment cannot be carried on by any person unless a license is granted by the Licensing Authority. For Cities it is the Municipal Corporation and for other areas it is the Zilla Parishad. The Licensing Authority also has the power to exercise general supervision over nurses practising within its area of jurisdiction.

Summary

In respect of each school of medicine, the Acts follow a similar pattern. The prescription of qualifications and standards of medical education (up to graduation level) are prescribed by the Central legislation i.e. are uniform for the entire country. On the other hand professional conduct and disciplinary action is dealt with by the respective State Legislation. The only exception being the Dentists Act, where there are no corresponding State laws. Post Graduation studies are in the hands of the States. Registration has to be at both the State and Centre levels but the significant registration is at the State level.

At both the State and Central levels the bodies which is overall in charge for overseeing the implementation of the Act are the Councils. Councils are partly nominated and partly elected bodies.

To begin with, the Councils are not as autonomous as they ought to be. Though a significant section of the Council is elected, there are large number of members who are nominees of Central and State Governments. This obviously affects the autonomy and subjects the Council to innumerable political and other collateral influences. There is no reason why elected representatives from the medical profession and from the medical faculties of the Universities, with only a sprinkling of Government Officers will not be in a position to oversee the implementation of the Act.

The other aspect affecting the autonomy of the Councils is the constant requirement of getting their decisions, especially those pertaining to qualifications, ratified by the Government. The elected representatives from the profession and Academic institutions ought to be capable enough to decide which qualifications are to be recognised and which institutions are to be granted recognition for which course and when their recognition has to be withdrawn. If at all, in these matters those elected from the Academic institutions ought to be given greater weight than mere practitioners. The only exception in this regard is the Nursing Council which is relatively more autonomous, not requiring the Government's sanction even for recognising foreign degrees. There is no reason why this example should not be followed in other Acts and the other Acts suitably amended to provide for such autonomy.

The third aspect about the Councils is the manner of elections. Under all the Acts, elections of the registered practitioners are required to be done by postal ballot. The

postal ballot system has been leading to many malpractice. Influential doctors and their representatives are known to collect envelopes from large number of doctors and file them with the registrar. At the very least what is provided in the Dentists Act should be made mandatory under all the Acts, namely that the envelopes should be sent by registered post alone. This can avoid some malpractice. However, ideally secret ballot through polling booths needs to be provided. This is the only somewhat guaranteed fair method of electioneering and there is no reason why the Medical Councils cannot resort to them.

This brings us to the next problem concerning the Councils namely finances. The Councils are largely financed by the Government which obviously leads to an erosion of their autonomy. The only other source of finance for the Council is the registration fees paid by the doctors. These fees are by and large laid down in the rules and remain stagnant, that too, at an extremely low level for decades together. When one is dealing with a creamy sector of the society, when the Government and the Courts have now approved charging of fees in lacks of rupees for medical education, there is no reason why substantially higher registration fees cannot be charged from the doctors for registration thereby making the Councils financially autonomous.

Lastly, the councils of nurses while having relatively more autonomy as an institution, is less controlled by the nurses themselves. For, it has greater proportion of medical bureaucrats, representatives of medical associations and councils, nominated members and even politicians in its membership. Besides, the all nurses acts lack teeth. This situation has created a big mess in the nursing profession. The nurses are in gross short supply, our country has one nurse for two doctors instead of having three nurses for one doctor. Obviously, we need four times more properly qualified nurses than their number today. Although no hospital or nursing home or maternity home can be run without nurses, the increase in their number has been unabated simply because, in gross violation of all medical and nursing norms and at the great risk to patients, the non-qualified women are openly employed in such an institution. This has helped the medical and other professionals to earn great profit for these non-qualified women are mostly not paid even minimum wages. The nursing councils have not been able to do much due to the stranglehold of the bureaucrats and doctors over their councils. Although the nurses associations and other representatives have, in government committees and elsewhere, often raised this issue the nursing council acts have not been reformed to give them more power and to weed out the non-nursing people from the position of power in the councils.

6. THE FUNCTIONING OF COUNCILS; A STUDY

We have examined the laws for the regulation of health care professionals, the functions and powers of their councils and the strength and weaknesses of the legal provisions in the last chapter Councils of health care professionals are gatekeepers between the state and the profession and between professionals and the public. To what extent have the medical and nursing councils been able to enforce accountability among professionals? How do they utilise the powers vested in them? What obstacles do they face in their day-to-day functioning? In order to be informed about these questions, we did a small study to of the councils for health care professionals in Maharashtra.

Note on Method

For this study we decided to collect the following four types of information:

(a) Review of studies of medical councils done so far in Maharashtra and other parts of the country.

(b) To obtain documentary information published by the councils, namely, their annual reports, other publications, information on the kind of cases of infamous conduct handled by them etc.

(c) Collecting information by providing them a questionnaire.

(d) Interview of the registrar or president of the council.

For obtaining studies done in the past on medical councils, we did a comprehensive search in various libraries in Bombay. We also went through historical documents on councils, the information culled from them have been narrated and analysed in the previous chapters of this report. We also went through the information on them given in various government and other committee reports. This information has also been analysed in the previous chapters.

To obtain documentary information on the functioning of the councils, the researchers visited offices of all councils in Maharashtra.

A questionnaire, sent as a letter, requesting information was sent to the registrar and presidents of all councils. The letter gave a brief introduction on the objective of the study, stated the intent and scope of our research, requested an appointment with the president and urged them to give information on the following among other things:

(1) Copies of all official publications to date. (2) Present and past rules and procedures on the recognition of medical and nursing schools and colleges, their inspection, recognition of degrees, etc. (3) Rules and procedures related to the

maintenance of the register - removal of names who have expired, migrated or changed residence, etc. (4) Information on the number of complaints of unethical conduct during the last five years and the results. (5) Number of *suo moto* actions taken by the council(s) against erring practitioners and results of such actions. (6) Action taken against practitioners working without proper registration or without a recognised degree. (7) Financial and administrative sources, position and problems faced by the councils and representations in this regard to the government. (8) Information about suggestions for amendments in the law and its rules by the council(s) to the government. (9) Ethical positions of the council(s) on issues like sex determination, organ transplantation, hysterectomies on mentally handicapped women, etc.

Our success in eliciting information from each of the councils hinged on our ability to get interviews with its key persons: the President and the Registrar. The fact that the Registrar holds an important position in the Council is amply evident from a review of their duties and functions. Registrars are effectively the real gatekeepers regulating the access of registered practitioners and the lay public to the councils.

Problems in data collection:

On making efforts to obtain past studies on the work of councils, we were greatly surprised to find that no study of that nature, of the national councils or state councils, of any of the health professionals done in last many years. Even the sociological studies of medical and nursing professionals are very few in this country. The inadequate interest shown by our social scientist in the health care professionals is very perplexing, for their counterparts in the developed countries have shown great interest in studying the world of health care professionals. Interestingly, our attempts to get good study of medical councils in the developed countries were also not so fruitful. The only council in which the sociologists have shown some but inadequate interest is the General Medical Council of England. On GMC, too, we found that some sociological information is available simply because in the 1980s, some sociologists were taken on the council as non-medical members. They provided some analytical writings on the functioning of the GMC. The rest of the material on the GMC comes from the medical journals and the reports of committees appointed to reform the GMC. Surprisingly, the first comprehensive study of the disciplinary functions of the GMC was published only in 1994, and this study too has suffered from lack of adequate information as the GMC was not ready to show their records on many issues. We reviewed this study at the end of this chapter. The information on the councils of other developed countries is even less accessible and there is hardly any good study available for comparison and discussion.

This situation makes us to suspect that the councils of health care professional across the world are (1) Very secretive about their work, and thus there is no transparency and accountability of what they are actually doing, (2) Apparently, many of them are very badly managed, thus making them more defensive than they need to be, and (3) They resent research or evaluation of their work by others, but at the same time they

also do not do a thorough self evaluation. Much of the material suggest that the changes brought about in the works of the councils are normally due to external pressure from the public rather than due to the efforts of professionals.

Whatever we could get on the councils was from the non-council sources: the writings of doctors in medical journals, newspaper reports and the experiences of complainant patients and health activists.

The task of meeting and acquainting registrars of the councils with the research under way was not easy. The reason for this is simple enough. They were not always available. The second task of getting appointments with the presidents and/or vice-presidents, leave alone getting them to talk, proved to be a greater challenge than we envisioned. For the presidents and vice presidents are fully engaged in their professional work, normally private practice. In some councils, they visit the council office only once in a week, in some, once in a month, or in one council we found that the registrar used to visit the office of president as there was not enough space in the council office. All in all, it was clear that the key officials of the councils were sparing very little time to pay attention to the work of the councils.

In one instance, after making thorough inquiries about the credentials of our organisation, we were given an appointment with the vice president of the Maharashtra Medical Council (MMC). However, when we showed up at the appointed hour, we were politely but firmly put down. Apparently, it was a decision taken in a previous council meeting that none of the office bearers -save the President- would deal with journalists, activists and researchers. Unfortunately, the President who resides in Pune was not easy to contact and more difficult to have a meeting with him. In the end, he also did not meet with our researchers.

At the nursing council, it turned out that the President of the MNC is the Vice-President of the MMC! Initially he told us that while he was not at liberty to opine on matters related to the MMC, he would tell us whatever we wanted to know about the MNC. He even said that he would show us how a council should be run. However, subsequently he changed and it was difficult to get him to talk to us. After calling up several times, we decided to ignore him and seek information from the registrar. Again we were stone-walled. In fact, the registrar, who has always been forthcoming in the past, was unwilling to talk and referred us right back to the president. This game of ping-pong went on for some time, and at the end both od them frustrated our efforts to have an interview with one of them.

This convoluted tale is intended to show up these councils for what they are -secretive and defensive. On reflection, the responsiveness of councils to our research agenda appear to bear some relationship to their status. This is why the ones that had little to lose by an interview were more inviting, at times dispensing with some of the usual formalities to accommodate us. That is why the Registrar of the Maharashtra Council for Indian Medicine (MCIM) not only spent a considerable amount of time in conversation but also offered to keep us posted with latest developments. At the

Maharashtra Council for Homeopathy (MCH) too, the president and vice-president who happened to visit the council on the day of our visit, made time for an interview without prior appointment.

It is obvious that councils -especially the dominant councils- are neither transparent nor readily accessible to the lay public. Information on certain subjects like inquiries conducted in the past and suo moto cases is virtually impossible to elicit. Specifics are never divulged; what one is served instead are broad guidelines about the procedures, which are in any case already available in the rules of the acts.

Annual reports and publications of councils: Here too we were greatly disappointed. No state council in Maharashtra publishes its annual report. Their other publications hardly given much information of research value. In fact much of the published information, all in all few small booklets if published at all, gave information on recognised degrees and procedures.

Maharashtra Medical Council

Although the councils for allopathic practitioners govern less than half the total number of registered practitioners in the country, they are more dominant than all the other councils put together. Much of the reason for this goes back into colonial history. Yet, the credibility of this body has taken a severe beating in recent times as stories in the mainstream press have focussed increasingly on their apathy and arrogance. For example, one of the newspaper reports focused on the fact that the Medical Council of India had failed to examine the ethical aspects of sex determination tests which were responsible for a high rate of female feticide (Katyal 1995: 7). The Central Committee on Sex Determination in fact noted that the need for legislation on the issue of sex determination would, perhaps, not have arisen had the medical councils taken note of this controversy and taken timely steps to lay down wholesome principles for the guidance of the profession in keeping with the interests and demands of society (quoted by Ravindra 1995: 13). Similarly, the MMC was reported to have taken no serious note of complaints from elected representatives during the kidney transplantation racket (Marpakwar 1995:1-3). However, the report of the panel constituted by the MMC to look into the kidney transplantation racket is yet to be released despite the fact that the panel completed consultation with other organisation a year back. A member of the organisation consulted by the MMC panel told us in the interview that during the discussion with the MMC it as clear that the MMC did not find anything unethical in the sale of kidneys by the unrelated donors to the wealthy purchasers. The MMC panel, however, was not so keen on making such views known to the public due to the bad publicity received by the kidney racket in the media. For all these reasons, fellow professionals and consumer activists feel that the MMC has "lost credibility" (Bal 1995: 8).

Medical Council Elections: In 1992, elections to the MMC took place after a gap of 10 years. In this elections, an eight member panel of doctors under the name. Forum for Medical Ethics contested elections. Their experiences of the elections are well

documented (Kamath 1993, Pandya 1993). In essence, they found much of the election process very irregular, unethical and decisively rigged by the powerful medical politicians. For instance, in public some candidate admitted that they were collecting blank ballot papers from doctors through their agents and these blank ballot papers were used by the candidates and their agents to cast vote. They found that on the last couple of days of polling, the candidates and their agents delivered suite-cases full of ballots to the council and the returning officer did not find anything unusual in such practice. At the time of counting also several irregularities were discovered. The media spotlight and the complaints made by the Forum to the government, the lokayukta etc could bring out the details of the way medical councils members are actually elected. Unfortunately, the media, researchers and concerned doctors haven't paid attention to the election process of medical councils of other states and of the national council.

Register: It was shocking to learn that the council has failed in maintaining a proper updated register. The register is not formally published, as required under the law, every year. Our effort to buy year-wise published register was unsuccessful. We made attempts to get guidelines and criteria used by the council for updating the register, but they were neither available in the written or published form or there was anybody at the council ready to explain the rational basis for updating the register. We also interviewed some health researchers who had used the list of manes contained in the MMC register for research purposes. We were told that in a study to map out health resources in a district in Maharashtra, they had used a number of lists, but not least of which was that provided by the medical council for the simple reason that it was not properly updated.

Enforcing discipline: Although the health consumer groups like ACASH Association for Consumer Action on Safety and Health, Bombay) and health activists groups like the Bombay group of the Medico Friend Circle claimed that there are over hundred complaints against doctors on unethical conduct pending with the MMC, there was no way to find out about the actual state of affairs as the MMC does not provide any data. There have been few instances of doctors being penalised for negligence or for violating the code of ethics. The MMC has been unable to produce a record of action taken against erring doctors, even when forced to do so in the past (Jesani and Nandraj 1994: 26). We, therefore, interviewed few complainants.

One complainant who had been successful in getting full inquiry and a judgement from the council declaring one leading doctor guilty on the charge of unethical conduct told us that he was successful primarily for two reasons: (1) Being an ex-administrator, he had very meticulously collected documentary evidences on his case. These documents were irrefutable. (2) It had been possible for him to get another doctor who had also handled the patient to testify, truly and objectively, but his testimony was strong enough to show the unethical conduct of the accused doctor. However, he was disappointed with the judgement which despite declaring the doctor guilty, only gave a warning as a punishment to the doctor. He had also filed a complaint against the same doctor for the appearance of his photograph in a magazine

with his full knowledge. In this case too the council had found the doctor guilty but awarded only warning as a punishment. It is interesting to note that both cases were heard at around the same time and the judgements were delivered on the same day, but in both cases the punishment awarded was only warning. In both judgement the guilty doctor was warned and asked not to violate ethics in future!

Interestingly in this case we were told that during the inquiry the complainant had wanted his journalist and doctor friends to remain present as observers in the same manner as people are allowed to remain present in the court rooms. He told us that the council rejected this request forcing Iris friends who had come to the council office go back. One of them had to file a case in the High Court to get an order to allow her to remain present during the inquiry. The High Court passed an interim order on February 19, 1990 directing the respondent (the MMC) "to permit the petitioners to attend all the proceedings of the inquiry being conducted .....". Thus, while the principle of such inquiries being public inquiry was established for time being, the inquiry got over before the case came up for the final hearing.

In our case study of another complainant, a businessman from Bombay whose wife died in a well-known private hospital in Bombay, some more issues on the way the inquiry on unethical conduct of doctors is conducted. The complainant told us that he lost his case in the preliminary stage of the inquiry. Interestingly, the complaints filed to the council are wetted by a committee in the initial stage before a charge-sheet against the accused doctor is framed. In this initial stage of inquiry, the complainant and the accused are called, but they are not allowed representation by their lawyers. He described his experience of the
inquiry in the following words:

"After I reached the MMC office and was waiting for my lawyer to arrive, I was told by the MMC that my lawyer would not be allowed to remain present. Thus I was forced to go inside alone. I do not like the impersonal atmosphere of court and so I was very scared. But to my initial pleasant surprise, I found two tables joined together and laid out for the inquiry. I thought at least here I wouldn't be as afraid as in a Court. But in no time after the inquiry started, my happiness gave way to depressing realisation that the informal non-Court atmosphere created at the scene of the inquiry was not for the benefit of the complainant. I found that informality was treated as an excuse for not keeping proper record of the proceedings of the inquiry and it was primarily to help the doctor. / was told that I would not be allowed to cross examine the accused doctors as it was only a 'preliminary' inquiry. Only the 5 executive committee members of the MMC would ask questions and nobody rise. With such a procedure and the sitting arrangement (I and the accused doctors on one side of the table facing five MMC doctors) made the inquiry resemble an interview in which I and the accused were queried by the interviewers in order to ' select* a 'truthful' candidate. Thus, in essence, the inquiry replaced search for justice by competition and selection.

Needless to add, in the interview for selection, more-often-than-not, it is the candidate with friendship and relation with the interviewers succeed. During the recess, I found the accused doctors and the MMC members talking and laughing together like old friends." Needless to add, at this preliminary stage only, the accused doctors were acquitted and so no charge-sheet was framed against them and no second stage of the inquiry was taken up. The complainant, aggrieved by this decision of the council, filed a case against the council in the high court to get the inquiry declared null and void on the ground of violation of rules of natural justice. He lost this appeal in the high court and told us that he has started preparation to drag the council in the supreme court on this issue.

The lack of transparency in the procedures adopted by the council is thus creating a sense of helplessness amongst patients and relatives. Of late, such cases have been getting wide publicity in the media resulting into the farther erosion of the credibility of the council. As this complainant put it, '1 would like to caution persons who desire to file a complaint against the doctors in MMC or in the court. It is not an easy job. The complainant should think twice before filing a complaint. It is not easy to win a medical negligence case. You will find yourself just banging your head against the wall. In the prevailing circumstances you will find lot of difficulties in proving the case. Also you will find hardly any doctor coming to assist you in the case".

The experiences of the complainants thus show that tine doctors have a close-nit fraternity of theirs, they would make all efforts to save the fellow doctors in the council inquiries. Some chance of getting justice is there only if the doctors are divided, that is, there are doctors involved in making the complaints. The latter aspect is also less developed. While it is well known that unethical practice of fee-splitting (cut-practice) is rampant, not a single complaint by any doctor on fee flitting has been filed in the council.

The state council for Dentists

The office of the MSDC is contained within a small room in a complex of offices belonging to the MMC. In the space that is left after all the cupboards have been positioned, the files and papers piled one over the other, there is just enough space for two table, a bench and a few chairs.

The characteristic feature of the council is its size: a staff of two to assist a registrar and a practitioners population of 6,505 are not what you call large. Further, unlike other councils, the MSDC is marked by an attitude of boredom, indifference even. The registrar, who is a retired ex-government employee, is rarely in the office. He has either been summoned by the president (who heads the Department of Orthodontia in the Government College) or simply on leave. The president never visits the Council office according to the registrar and the clerk. Also, council meetings never take place in the office due to the lack of space, they are normally conducted in the government dental college. This is why the impression that greets a lay visitor is one of inactivity.

When we finally met the elusive registrar, we were pleasantly surprised by his co-operation and his relatively open attitude. Indeed, the wariness that typifies the other council in the vicinity had not yet set in. This can be explained by the fact that he is a relative newcomer, having been in the council for a mere six months. We also discovered that there were no takers for the post of registrar due to poor pay scales. Previously, the post was entrusted an employee of the Directorate of Health Services, who was unable to devote much time to council affairs. So a retiring colleague was persuaded to take up the job for the opportunity it gave to keep busy (rather than earn a regular income).

The MSDC is a fairly impoverished council if the registrar's off-the-record conversation is anything to go by. Previously a grant from the state government kept the council afloat. Now that the grant has ceased to be, the council whose major source of revenue is registration fees, is required to scrimp so as to regularly pay the salaries to its two employees - a peon and a clerk. Representations to be allowed to increase registration fees to the central council and to the state government have so far been unheeded. The MSDC levies an initial registration fee - a paltry sum of Rs. 100 which is followed up by an even smaller annual renewal fee of Rs. 15. If practitioners fail to pay up, stern warnings are dispatched by the council along with a late fee charge of Rs. 10. Since the council accepts renewal fees annually, the register is updated constantly. The onus of informing the council about migration or death of practitioners lies with the respective practitioners and their families.

The Registrar did not know the total number of the cases of unethical conduct brought up before the Council in the last five years. However, discussions with the peon and clerk who have been there for a longer time revealed that an average of one case per year would have come up since 1990. In any case, the Registrar holds the belief that none of the complaints coming before the Council are serious. The state council for Indian Systems of Medicine The MCIM, which is there to govern the 28,000-odd registered practitioners of what are known as the Indian Systems of Medicine, namely, Ashtang Ayurveda, Sidda, *Unani* and Tibb is housed on the uppermost floor of one of the early buildings of South Bombay. The council office looks weary with age but exudes a certain charm. The MCIM is run by an experienced, dynamic and politically savvy registrar with a staff of six friendly, responsive and obliging people. An air of informality pervades despite the presence of "secretaries" and "appointments". The Council is also characterised by a certain absence of activity - the only people who drop in are the occasional student wishing to get registered and acquaintances of the registrar asking for favours. It is not always easy to find the registrar in his office because he is frequently expected to put in an appearance at the Mantralaya where the Deputy Secretary, Medical Education is seated.

Of all the councils, the MCIM was the most open and the reason for this could be the fact that it has so little to lose. The motivation to self-regulate through the facility of a council sounds ironical when you consider the fact that no council exists at the present moment. What existed until 1982 were the Board and Faculty of *Ayurvedic*

and *Unani* Medicine in accordance with the requirement of the 1961 Act. The former concerned itself with the medical practice of registered practitioners while the latter was focused on the question of medical education. The amendment in 1982 stipulated the dissolution of the Board and Faculty and the institution of a council with 19 members in its place. It is 13 years since this radical restructuring and there is still no council in sight, despite periodic representation by the registrar to the State Government in this regard. What exists instead is the authority of the Administrator even though the persons who have occupied this seat have changed with unfailing regularity. According to the Act, the Administrator should be the Director of Ayurved, a technical person employed at the Directorate. However, the post has been handed over to the Deputy Secretary of the Department of Medical Education as an additional responsibility. The current Deputy Secretary and her predecessors have reportedly not visited the MCIM offices.

There are at present in addition to government colleges, 14 aided colleges and 17 unaided colleges for the teaching of ayurveda. The number of *Unani* colleges are four, of which three are aided and one unaided. The number of non-aided colleges have been increasing at an alarming rate in the recent past. It is from the point of view of these private colleges that he absence of the council is 'godsend'. These colleges with reportedly non-existent facilities get recognition through their connections with politicians. According to the registrar, these elected representatives instruct the deputy secretary to "inspect the college and come back with a favourable report." Given his redundant role in the process of recognising medical institutions and universities, such information does not routinely come the registrar's way and he does not really bother to seek updates from the state secretariat. So the activities currently undertaken by the MCIM is focused exclusively on registration of new graduates and maintenance of the register.

Member practitioners pay a one time registration fee ofRs.500. There is no renewal of registration. The absence of renewal saves the council and its registrar the administrative work associated with it, but at the same time, it makes the updating of register highly inadequate.

The MCIM plays no role in disciplining members and this is not really surprising, given the fact that no council exists at the present moment. With the non-existence of a state council, a vital avenue for redress in the event of doctor's unethical professional conduct has ceased to be. According to the registrar in last five years, only two complaints were lodged.

The council for Practitioners of Homeopathy

The MCH has a staff of more than 10 persons in various clerical positions and bustles with bureaucratic formalities. Peons and clerks walk in and out of rooms delivering and collecting files. The registrar functions behind a closed door. The registrar did not personally attend to even one of the queries that had been put up in the letter. Instead, he directed us to one of the office clerks. This gentleman provided only the most

perfunctory of responses. "As per the rules" seemed to be his patent line even though we were not given the opportunity to learn what these rules might be. A request for copies of official publications was first treated positively. However, this was later turned down by the registrar who maintained that they did not have copies of all publications and it was not possible for them or us to have them photocopied. They did, however, have copies of the syllabus and Minimum Standards of Education Regulations, 1983, both Central Council Publications, which they sold at twice the printed cost.

The Council consisting of II members was constituted as recently as 1992. Before 1992, an Administrator took on the responsibility of running the council. The President and vice- President do not reside and practice in Bombay (in fact, only two members are residents of Bombay). They visit the office once a month. At present, the Council's role in regulating medical education consists of inspections to ascertain that minimum standards as laid down by the Central Council are met.

According to the President and Vice-President, an average number of five to six complaints get lodged a year. The Council reviews them and refer them to the police as they deem fit. The Council cannot control medical practice in anything but a passive manner.

The heads of the Council endorse cross practice and feel that the Act should make provisions to that effect. The Council feels that their proposed amendments are not taken seriously. Only two out of 28 amendments submitted over the years have been accepted. One long standing demand is for legitimacy for cross practice.

Concluding Note

From the narration of our experiences with the medical councils in Maharashtra state it is clear that either they are not doing the work in the manner prescribed in the laws and their rules, or the members of the councils are plainly indifferent to the task assigned to them, or that the structural constraints of the paucity of funds, good qualified employees and the constant bureaucratic and political interference are making them passive. Perhaps, all these factors contribute to some measure in making the councils from defaulting in their roles.

Interestingly, there is no possibility, at least at present, to get any hard statistical information from the councils. The councils are reticent to talk to researchers, media people and health and consumer activists. This attitude to opening their documents even to genuine research is perplexing for the simple reason that there hasn't been any research done by any institution on the councils. Worst still, while prohibiting research from other institutions, they do not have their own evaluations and annual reports.

During our several visits to the councils we also noticed that the functionaries of the councils were called by the bureaucrats of the state secretariat in the same manner as

the persons from the health and medical education directorates of the state are called. While there is some scope in the law for the councils to assert their autonomy, there seems no interest on the part of the elected members to assert such autonomy.

One might say that this attitude of the councils could be due to their monopoly in the medical practice. Such monopoly breeds arrogance, complacency and above all non-accountability. However, in the case of these councils, this is true only to a limited extent in the sense that the councils do not seem to even assert the monopoly over their trade. For instance, all these councils have done nothing on record to weed out practitioners who are not registered with any council. The allopathic council seems to have taken no step to prohibit cross system practices which encroach on the monopoly rights of their members to practice modern system of medicine. During our encounters with them we found that the council members seemed to have an opinion that kidney trade as it was carried on before the new central law was enacted, was not unethical. Though we do not agree with them on this count, it is noteworthy that the council was reluctant to make such views known to people, so much so that after appointing one panel to examine the issue, it is not prepared to release its report.

Even registered practitioners are all but officially cast out of the regulatory mechanism of the councils. Mostly, this regulation is passive. There appears to be no evidence of substantial number of suo moto inquiries and the major form of disciplining is in response to written complaints. Even if complaints are put through the orchestrations of full-fledged inquiries, they rarely result in the enforcement of punitive measures. The in-camera proceedings rule out the possibility of public censure and de-registration rarely takes place. Therefore, the councils function more as guild bodies protecting the self-interest of the profession than as regulatory bodies which enforce some social accountability in the profession. Some activists have labelled them as "irresponsible trade unions" whose self- interest overrides public interest (Ravindra 1995: 13). Other reporters wager that they (especially the MMC) have become "virtually defunct" (Marpakwar 1995: 1-3). Such allegations are finding more receptive audience all over the country. After-all, given the ills prevalent in the medical care system, how can one explain near absence of actual disciplining of even a token number of registered doctors who number almost a million in the country?

The only consolation that councils in India can take is from the fact that they are not the only councils whose work is shrouded in mystery. Perhaps the best run medical council in the developed world is that of England. However, the evidence on its functioning also show that, although it seems to be doing lots of good things, everything is not so well with it too.

General Medical Council (GMC), UK

The GMC was created by an enactment of law (called Medical Act) in England in 1858. It was a culmination of almost half a century of struggle launched by the general medical practitioners (GPs) to weaken the stronghold of Royal colleges of physicians and surgeons over the profession and to get registration/recognition for

themselves (Waddington, 1984). The primary objectives of the Medical Act, discussed at length in the parliament, public and within the medical profession; were for registration of all doctors and for streamlining medical education and the examination system. The third objective, now well known in relation to medical councils world over, of regulating professional conduct or medical ethics or medical discipline, was not so pronounced. Indeed, the reference to that aspect in the Medical Act constituted half a dozen inconspicuous lines and that section was not discussed at all in the discussion that took place in the British parliament, save for one member passingly wondering about the GMC having some authority to supervise and control (Smith Russel, 1994: 1). However, in no time the GMC was approached with cases.

Russel Smith's (1994) book, based on his doctoral dissertation, deals with the GMC's performance on this count from 1858 to 1990. It is a monumental study made possible by some amount of transparency maintained by the GMC and the availability of data. Despite that, as he states in his introduction, the task was not easy. For a good deal of the operation of jurisdiction by the GMC is carried on in private, such as the preliminary screening of cases, the operation of the health jurisdiction, and the quasi-disciplinary jurisdiction of Overseas Committee L and Registration Committee. He was denied access to the non-public activities of the Council. Thus his study is based only on the public sitting of the disciplinary committee and the material reported in the GMC's minutes as well as the medical and lay press (Ibid: 17). Thus, the secrecy surrounding medical councils in India is not so unusual. We have modelled our medical council acts to those in the UK, and so access to information from the Councils is almost impossible. While the GMC has some transparency and Smith could avail of information of public sittings and from the minutes, in India the councils' minutes are confidential documents, its disciplinary or ethics committee's functioning, including inquiries, are not open to public, and we could not find public sitting of council for any work. As a result, we were denied information vital for assessing the work of medical councils in India.

Nevertheless, the information provided by Smith is of great value. Accordingly, between November 23, 1858 to December 31, 1990, 2015 individual practitioners are reported to have been involved in public disciplinary proceedings conducted by the council, and some 2316 separate charges were dealt with (Ibid: 97). Thus, in the period spanning 132 years, on an average 15 doctors were tried for under the charges related to discipline every year by the GMC. The alcohol offices constituted 13.44%, sexual offences 12.14%, financial offences 11.58%, certification 9.62%, drug offences 9.9%, neglect 7.79%, attracting patients 8.7%, unregistered practice 6.74%, covering/delegation 5.41%, abortion 3.55%, drug prescription 3.12%, offences against the person 3.33%, un-stated/other 2.81%, false registration 1.02% and lastly breach of confidence/consent 0.85% of 2849 cases indexed from the GMC documents by Smith. Interestingly, of the 2849 cases tried in public by the GMC, the charges against 641 (22.5%) were not proved, while the rest were penalised.

Like in the case of medical councils in India, all complaints files with the GMC are first screened by the president. Russel Smith (Ibid: 9) has done an analysis of

complaints filed in one year, September 1, 1989 to August 31, 1990. He found that of 949 complaints received by the GMC in this period, the screening procedure was pending for 218 (22.75%), 168 (17.7%) of them were referred to the NHS, in cases of 355 (37.4%) it was decided to take no action, 10 (1.05%) were withdrawn, 51 (5.37%) were disposed off with letter of advice and only 147 (15.5%) complaints were sent to the Preliminary Proceedings Committee (PPC). The PPC sits in private and scrutinises these complaints further, and only if found suitable, refers them to the Professional Conduct Committee (PCC) for full public hearing or what is known in our country as trial. Thus only a small
proportion of complaints are actually heard in public, the adversarial evidence led and penalty or no-penalty for the accused passed.

Sickness and incompetence: Two important problems of medical profession, sick and incompetent doctors fall within the purview of self regulation of medical profession, but the profession has taken cognisance of them very late. While sickness has been legally brought within the jurisdiction of the GMC by the Medical Act, 1978, for dealing with competence no special mechanism exist within the GMC except through its disciplinary machinery. This does not mean that incompetence among doctors is negligible. Richard Smith (1989) reports the prevalence of incompetence to be of the order of 10-15% of independently practicing doctors- that is consultants or principals in general practice, in England.

The sickness amongst doctors is handled by health committee of the GMC on receipt of complaints. Here too it is stated that the deficiency in its machinery lies not in its effectiveness in dealing with doctors it encounters but rather in its failure to make contact with many of the sick doctors who are putting themselves and their patients at risk, Between August 1980 when the system began and October 1988, the council received reports on 383 doctors. Roughly a third are not examined by the health committee, another third are successfully rehabilitated and the remainder are suspended, accept voluntary erasure or die (Smith Richard, 1989).

Interestingly, while in the UK it was after 130 years of existence of the GMC that legislation was made to incorporate function of rehabilitating or suspending sick doctors, no such provision in the medical council acts in India takes cognisance of sickness among doctors and risk posed by it to the patients. And this is very serious situation, as the doctors normally do not retire from the medical practice, the old age or illness not withstanding. When one looks at the sickness in combination with the incompetence in India, the situation would seem more alarming. For unlike some of the developed countries, there is no well organised programme of continuing medical education for doctors in India. Some of the councils just do one time re-registration, not requiring any re-registration at any time thereafter. So they do not believe in continuing education and in ensuring competency of practicing doctors. The allopathic council on the other hand renews registrations periodically, but that is a mere formality as it is not tagged to any proof of undergoing upgradation of knowledge and skill and continuing education. Given the fact that a very big majority of our doctors practice independently (even those who are institution based are not

fully immune to this), the proportion of them being incompetent in the trade they claim expertise would be very high.

Evaluation of the performance of GMC: Most of the commentators seem to agree with Russel Smith's (1994: 221) contention that the original jurisdiction and concept of disciplinary regulation of a profession was inadequately thought out in the mid-nineteenth century and unfortunately the jurisdiction has changed little in the matters of substance since then. Russel Smith (Ibid. 223-226)categorises his evaluation into seven categories:

(1) Legality: On the whole legality is not questioned. However, the issue of illegality due to conduct of some proceedings in camera, the way charges are pleaded, absence of legislative authority for the sanction of admonition and postponement etc remains open. (2) Fairness: Some unfair aspects involve in some cases denying legal representation to practitioners, in early year the practice of sending letters of advice and admonition without giving a hearing to practitioner, failure to give adequate notice, cases involving disputed medical theories, failure to give reasoned decision, etc. (3) Accountability: This is the biggest problem arising from the preliminary screening done in private, the information on the basis on which cases are detected for public hearing, the failure to state policy consideration for the use of various sanctions, etc. (4) Impartiality: Although extraneous influence seems to have been kept out, certain biases have been reported. For example, sitting of members on the committee having known political and professional views on the complaint being heard, the legal assessors having represented the accused practitioner in prior criminal proceedings, the legal assessor assuming the role of cross examining counsel during the proceedings, etc. (5) Effectiveness: In terms of its objective of protecting the public and setting and maintaining acceptable standards of professional conduct, the GMC is ineffective in many ways. They are: the delays, absence of reasoned decisions, limited publicity, no training and instructions to members of PCC prior to hearing cases, lack of reliance on precedents in decision making, limited use of expert opinion, and lastly, frequently changing membership of the PCC resulting into lack of consistency in decision making as well as in the imposition of sanctions. (6) Efficiency: This is another great problem. A reason for it is inadequate resources in terms of funding, staffing and accommodation. The PCC sits only in three sessions in a year, increasing the length of adjournments. (7) Openness: This is fairly clear, a great deal of work of the GMC done behind close doors with limited reports being disclosed in council's minutes and annual reports.

Another commentator, Richard Smith (1989a, 1989b, 1989c, and 1989d) wrote a series of articles on inadequacies of GMC and need for reforms. Richard Smith's findings are similar to Russel Smith's findings. For instance, he says that every year the GMC receives about 1100 complaints from four main sources: the police (70), the NHS (50), doctors (200) and the public (800). Thus, the direct approach by the public to the GMC is the highest. He also takes critical look at the function of first screener of cases, the president and says that less than 15% of cases are referred to the PPC by the president. The sittings of the PPC is the first serious stage in the disciplinary

process, and yet its proceddings are carried on in private. He analyses the outcome 143 cases concerning 127 doctors considered by the PPC in 1988. It was found that, in 6 cases the proceedings were adjourned for consideration, 19 cases adjourned sine die, on 10 cases decided to take no action, in 64 cases letters of advice or admonition were sent to doctors and only 44 cases were referred to the Professional Conduct Committee for public hearing. Thus, the PPC filters out more than two third of cases, allowing less than one third to be publicly heard. As compared to about 1100 complaints filed every year, this proportion (only 4%) of cases going for public hearing is very low.

Margaret Stacey (1989), a sociologist who was a lay member of the GMC from 1976-84 is equally critical of the way council works. She makes an interesting observation that most of the changes in the GMC's work came as a result of external pressure, albeit pressure that gave the forward looking members of the council opportunities to propose reforms. She discusses the question raised everywhere: can a doctor dominated body ever adequately discipline doctors in the public interest? One suggestion is to hand over the function of discipline to the law. Another is pass the control over discipline to a totally lay body. While discussing these suggestions, she proposes that better way would be that from the start doctors, patients and potential patients work together to improve the system.

7. Laws and Regulations for Hospitals

The medical laws governing hospitals and nursing homes are difficult to find in our country. Apparently, at present there are only two legislation in force, in states of Maharashtra and Delhi.

The Maharashtra legislation on the subject came in the spotlight four years back when it was found that it was inadequate and the enforcement authority under the act was doing little to discharge its duty. A public interest litigation on this issue prompted the Bombay High Court to appoint a committee to supervise its proper implementation but that has so far not helped much in activating the state and local machinery.

The second legislation for Delhi also came under strong criticism four years back. Reportedly, due to media outcry, the Delhi law or its rules are being modified/amended. However, when we made a visit to the concerned officials in Delhi to get a copy of the changes made, we were politely told that although the draft was ready, it was still a "secret" document. Since then we haven't heard about the enactment of the modified law or amendments in the existing law. Here we have studied only the Delhi Nursing Homes Registration Act, 1953 and not the rules under the act as they were not accessible.

A third legislation, in Karnataka, passed during emergency as an Ordinance, titled "Karnataka Private Nursing Homes (Regulation) Ordinance, in 1976 and rules framed with extraordinary efficiency in the same year, does not seem to be in force at present. Our efforts to get clear idea on the fate of this ordinance were in vain as the response from the state health ministry and the directorate of health services only stated that there was no law in existence in Karnataka for registration or regulation of nursing homes. This was confirmed later on by a newspaper report that the Karnataka government was contemplating a law for registration and regulation of nursing homes.

We decided to study the 1976 Ordinance and the rules under it. Unfortunately what we could obtain after great efforts was only rules under the Ordinance and not the text of the Ordinance. Yet, it is clear that it is the only law which is tilled as "regulation " law and not the "registration" law. As we would see, it had some features which make it more comprehensive and tells us why Devraj Urs, the emergency chief minister of Karnataka, was loved as well as hated equally.

The Bombay Nursing Homes Registration Act, 1949.
The Bombay Nursing Homes Registration Rules, 1951.
The Delhi Nursing Homes Registration Act, 1953.
Karnataka Private Nursing Himes (Regulation) Ordinance, 1976.
Karnataka Private Nursing Homes (Regulation) Rules, 1976.

The Bombay Nursing Homes Registration Act, 1949

Of all medical acts regulating nursing homes, this Act is the oldest. It was enacted with three distinct purposes, (1) to provide for registration of Nursing Homes (NHs), (2) to affect inspection of NHs and (3) to provide for other purposes connected with registration and inspection of NHs.

It is interesting to note here that the act was passed in the old Bombay state. After reorganisation of states in 1960, Gujarat and Maharashtra states adopted most of the old Bombay state acts. However, Gujarat made one of the few exceptions. Gujarat state failed to adopt this act. Thus, presently this act is applicable only to Maharashtra state.

Interestingly, in 1949 when this act was passed, it had restricted application. While the act was meant for the whole of Bombay state, in its first stage of implementation it covered only three cities. Greater Bombay, Pune and Ahmedabad. In 1960, while adapting this act, the Maharashtra Government dropped Ahmedabad (being in Gujarat) and extended it to Nagpur and Sholapur. Thus, while Gujarat has not adopted this act, in Maharashtra it is applicable only to NHs in four cities. The state government is empowered by the act to extend it to other areas of Maharashtra but despite massive expansion of private nursing homes in all corners of the state, the govenment hasn't found it necessary to issue notifications for extending the act to all districts, towns and cities.

Definitions:

The Act defines NHs and Maternity Homes (MHs). The definitions are very significant.

Nursing Homes (NHs) are defined as, "any premises used or intended to be used, for the reception of persons suffering from any sickness, injury or infirmity and the providing of treatment and nursing for them, and includes a maternity home; and the expression 'to carry on nursing home' means to receive persons in a nursing home for any of the aforesaid purposes and to provide treatment or nursing for them".

Maternity Homes (MHs) are defined as "any premise used or intended to be used for the reception of pregnant women or of women in or immediately after child birth".

Accordingly, since the definition of the NHs include MHs, all MHs are by definition, NHs. In other words, the MHs are those NHs which cater to pregnant women and women in or immediately after child birth. Secondly, the NHs provide treatment of all kind as well as nursing care. That means, even a place keeping patients only for day care and providing nursing care are also NHs. Consulting rooms and clinics providing only outpatient care are excluded. Lastly, all hospitals are NHs and all NHs are hospitals. Thus, the size of the institution does not matter. What is crucial is the services provided.

The Act also provides definition of the health care personnel. Accordingly, "qualified medical practitioner" means a medical practitioner registered under the relevant Medical Act in force; and a "qualified midwife" and a "qualified nurse" mean one registered under the relevant Nurses, Midwives and Health Visitors Act in force.

Structure of the Act:

The Section 3 of the Act expressly prohibits establishment and running of the NH without having proper registration.

The Act provides for: (1) Constitution of local supervising authority for registration, inspection and framing by laws for the NHs. (2) Defines procedure for registration or renewal of NHs. (3) Provides powers to the local supervising authority for inspection. (4) Defines ground on which the application for registration or renewal could be rejected or the existing registration could be cancelled. (5) Provides penalties and other means to deal with the offences under the Act. (6) Lastly, provides for the local supervisory authority to frame by laws on matters specified.

(1) Local Supervisory Authority: The local supervisory authority "in the case of municipal area means the municipality established for that area, and in the case of any other area a district local board established for the said area" Accordingly, the Municipal corporations and municipalities for the cities of Greater Bombay, Pune, Nagpur and Sholapur are empowered to act as local supervisory authorities. Since no notification is issued for covering other municipal areas of Maharashtra, the municipalities or municipal corporations in those areas do not have such authority. Similarly, for the non-municipal areas (means most of the rural Maharashtra) local boards are not established as the Act is not extended to the rural areas at all.

(2) Procedure for Registration and Renewal of Registration: This is indeed very simple. The NHs make an application for registration or for renewal of registration in a prescribed form along with the fee. Normally, there is an inspection of the premises of NH by a representative of the local supervising authority before the application is cleared. However, there is nothing in the act to make such inspection mandatory before granting registration or renewal of registration. Since nothing is said in the act, it is left to the discretion of the authority to affect pre-registration inspection. Therefore the registration could be given without making inspection

(3) Inspection: Section 9 of the Act empowers the Health Officer of the local supervising authority or the Civil Surgeon of the district in which the NHs are located, or any other officer duly authorised by them, to enter and inspect the premises used as the NH. However, they are barred from inspecting the medical records of any patient of the NH, The refusal to allow entry or obstruction in inspection is termed an offence under the Act.

(4) Grounds for rejecting application for registration or renewal: Interestingly, the only place where some medical scientific criteria for registration formulated are in Section 5(1) (a) to (d), and they come under the grounds for denying registration or its renewal. There are four grounds formulated, each one is important:

(a) That he, or any person employed by him at the NH, is not fit person, whether by reason of age or otherwise, to carry on or to be employed at a NH of such a description as the NH named in the application.

(b) That the NH is not under the management of a person who is either a qualified medical practitioner or a qualified nurse and who is resident of in the home, or that there is not a proper proportion of qualified nurses among the persons having the superintendence of or employed in the nursing of the patient in the home.

(c) That in the case of MH it has not got on its staff a qualified midwife.

(d) That for reasons connected with the situation, construction, accommodation, staffing or equipment, the NH or any premises used in connection therewith are not fit to be used for a NH of such a description as the NH mentioned in the application or that the NH or premises are used or are to be used for purposes which are in any improper or undesirable in the case of such NH.

The refusal to register or renew a NH, and the cancellation of registration of existing NH, involves a long procedure to be followed by the supervising authority. The Section 8 (1) to (4) lay down the procedure. Accordingly, it must give a minimum of one month's notice to the NH giving full ground for its intention to make such an order. The NH has a right to reply, showing cause(s) as to why such order should not be made. Even after that, the supervising authority passes such an order, the NH has a right to appeal against such an order of refusal to the State Government. The state government's decision on the appeal is final. Further, the refusal or cancellation order does not come into effect until the appeal to the state government is decided or withdrawn.

Penalty for offences: They penalties are prescribed for violation of the Act. The running of NH with out registration invites a fine ofRs.500 and if the offence is committed again, the fine and/or an imprisonment up to three months are prescribed. Similarly refusal to allow inspection or obstructing it is also an offence. Contravention of any other provision of the act is punishable by fine up to Rs.50 and continued offence is punishable by a fine ofRs.l5 for each day of the continued offence.

(6) By laws to be framed by the local supervising authority: There is limited power given to the local supervising authority for framing by laws. It can frame by-laws on: prescribing records to be kept of patients, records of miscarriage, abortion, still birth, births etc, and notification of deaths in the NH. It also empowers the local authority to

fine up to Rs.50 for an offence and also to fine up to Rs. 15 per day for continued offence against the by-laws.

The act makes it mandatory on the part of the NH to affix the certificate of registration at a prominent place in the NH.

Non-applicability of the Act: The act expressly leaves out NHs run by the government, local authority or by any other body or persons approved by the State Government and the lunatic asylums, from the purview of all provisions of the Act.

The Maharashtra Nursing Homes Registration Rules, 1973

The Bombay Nursing Homes Registration Act, 1949 has a wide scope. It is not simply a registration act but also regulation act. The Act also empowers the state government to make rules on (1) prescribed form of application for registration or renewal of the NH. (2) date on which the renewal will be done every year, (3) the quantum of fees chargeable for registration and renewal. (4) the format or form of registration certificate. And lastly, but importantly, (5)
on any other matter for which no provision is made in the Act.

Some of the important provisions include:

(1) The prescribed format of the register to be maintained by the local supervisory authority (Form "A").

(2) The prescribed format of application for registration to be made by the owner of the NH (Form "B"). This is an important document. It covers: (a) Detailed information on the applicant, (b) Location of the NH. (c) details of the space, for beds, servants' rooms, kitchen, storage rooms etc. (d) arrangement made for medical check-up and immunisation of the employees, (e) whether NH premises is used for any other purpose, (f) no. Of beds for maternity patients, no. of beds for other patients, (g) names, age, qualification of the nursing staff, (h) accommodation for the nursing staff, (i) names, age, qualifications of resident and visiting doctors, (j) whether NH is under supervision of a qualified doctor or a qualified nurse, and if so, their names, age and qualification, (k) the proportion of qualified and unqualified nurses on the nursing staff. (1) whether any unregistered medical practitioner or unqualified midwife is employed in the NH. (m) whether any person of alien nationality is employed in the NH, if so name and other particulars, (n) fees charged to patients, (o) whether the applicant is having interest in any other NH, if so details of such NHs.

(3) The third form prescribed by the rules is the format of Certificate of Registration.

(4) There are some miscellaneous provisions, such as, intimation of transfer of ownership, change of address, change of staff, about lost certificate, etc.

Delhi Nursing Homes Registration Act, 1953

This Act is a verbatim, section to section, copy of the Bombay Nursing Homes Registration Act, 1949, except that the Section 17 of the Maharashtra Act which empowers the local supervising authority to make by-laws in certain matters is not there in the Delhi Act. The similarity is so much so that all definitions are identical, and Sections I to 16 of the same as the both the Acts. Since Sections 17 of the Maharashtra Act is missing from the Delhi Act, the Section 18 of the Maharashtra Act is identical to the Section 17 of Delhi Act.

The only difference being: (1) The word Bombay is replaced by Delhi. (2) The applicability is not restricted to few localities of Delhi, as the Maharashtra Act restricts itself to 4 cities. This Act is made applicable to the whole of Union Territory of Delhi (now state of Delhi). (3) The words. State Government in the Maharashtra Act are replaced by Chief Commissioner. This difference is gone now after constitution of the state of Delhi.

Thus, in all respect, the Delhi Act is identical to the Bombay NH Registration Act, 1949.

Delhi Nursing Homes Registration Rules, 1953

The Rules under the Delhi Act incorporate all points in the Bombay Nursing Homes Registration Rules, 1973.

Thus, the Forms A, B and C under the Delhi rules are identical to the Maharashtra rules. Miscellaneous points like intimation of transfer of ownership etc. mentioned in Maharashtra rules are identically present in the Delhi rules.

The Delhi rules have few provisions, which are different from those available under the Maharashtra rules.

(1) For the purpose of registration fees, the Maharashtra rules categorise NH only in two categories, up to 10 beds and more than ten beds, the annual fee for the former being Rs.50 and for the latter, Rs. l00. In the Delhi rules, there the categorisation is up to 10 beds, more than 10 but up to 25 beds and more than 25 beds. The annual fees chargeable are Rs.30, Rs.50 and Rs. l00 respectively.

(2) In the absence of Section empowering the local supervising authority (called "local authority" in the Delhi Act) to make by-laws, the matters on which the by-laws are to be made by the local supervising authority are incorporated in the Delhi rules. Accordingly, the Section 12(1) of the Rules gives the format of records of the patients admitted, of maternity cases, of miscarriages, abortions still births etc to be maintained by the NH, and the Section 13 gives the procedures and format in which the deaths in the NH to be reported to the local authority.

Thus, in all essential matters, the Maharashtra and Delhi Acts and Rules on the NH are identical.

Karnataka Private Nursing Homes (Regulation) Rules, 1976

As explained earlier, despite our all efforts we could not locate the Karnataka Private Nursing Homes (Regulation) Ordinance, 1976, of which this piece of legislation constitutes the Rules. Irrespective of whether the said ordinance was ratified by the Karnataka assembly, this legislation is evidently only a part of history of the health care legislation. For at present, it is not in force. As per the communication received by us in response to our questionnaire from the Directorate of Health and Family Welfare, Bangalore, there is no law in Karnataka under which the private NH are required to be registered, let alone to be regulated as this 1976 Ordinance envisaged. The response to our questionnaire further states that no inspection whatsoever of the private NHs done in Karnataka, and that there are no guidelines existing for the maintenance of minimum physical standards in the private NHs in Karnataka. Curiously, the Directorate skipped our question on whether there are guidelines for minimum physical standards for the government and local bodies hospitals and NHs giving an impression that even in the public sector no such guidelines are existing.

Some distinguishing features:

First of all, on looking at the Rules of this Act (or Ordinance), it is clear that it was a very serious and farsighted piece of legislation enacted way back in 1976 during the traumatic period of the state of emergency in the country, A cursory reading of the rules show that as compared to all other legislation on the subject, it is written in clear simple language. Each point is made straight, with the least legal jargons. Although it does keep powers with the bureaucracy, its points are made unambiguously.

Second, instead of talking about "registration" as the central purpose of the legislation, it makes no bones about its intention to regulate. Not only that, it says in a straight forward way that a permission from the competent authority needs to be obtained in order to establish a NH. Thus, it is an application seeking permission, not an application for simple registration. Some people may find the language used offensive, but it drives home the point that one is not
dealing here with a formality, but a serious proposition of passing standards set by the authority for running a NH.

Third, the grant of permission to run the NH is firmly linked to the standards and other requirements that the NH must satisfy.

Four, for the first time in such legislation one finds the clear-cut definition of minimum standards and full description of each item included in the standards.

Five, the legislation goes beyond the standards, it also defines the ceiling of fees to be charged for different kind of services provided at the NH.

Six, in a very important departure from the norm that the regulatory mechanism on the private sector leave out public sector and the that on the public sector leave out private sector, this legislation sought to bring the private NHs under the purview of national priority health programmes. It made it mandatory for the private NHs to implement the national health programmes One may debate wisdom of "forcing" the private health sector to undertake non- profitable public health work, there is no doubt this was one of the boldest step to make the entire health sector to confirm to the national health priority.

Seven, on the negative side, it must be re-emphasised that it gave much more power to the bureaucracy and negligible role to people and the consumer.

After summarising these distinguishing features, let us try to understand the specific provisions of this legislation to the extent we can understand from the rules available with us.

Definition of NH:

Although the rules do not explicitly define NH (such definition is normally in the Act), the way it classifies the NHs gives an idea that what is kept implicit in the Maharashtra and Delhi legislation is made explicit. Accordingly, it talks about the NHs with inpatient facility and the NHs without inpatient facility. Thus, the NH seems to be a place where treatment and nursing care is provided irrespective of whether such care is inpatient or not. Thus, most of the private clinics would also come under the purview of this act.

Competent authority:

Competent authority for granting permission for establishing and renewing the permission for continuation of NH is the Department of Health and Family Planning Services, Government of Karnataka. Thus, the department along with its peripheral structures (Civil Surgeons, District Health Officers etc) and not the Municipal and Panchayati Raj local bodies, are made the competent authority.

Permission for establishing a NH:

Throughout the text of rules, the term registration is not mentioned at all. Instead, the term permission is used. There is no mention of registration certificate either. Instead, it is again the term permission. One may call it the much maligned "permit". It is interesting to note that, in all other medical laws, including the Medical and Nursing Council Acts, the term permission is conspicuous by its absence, except of course in this short lived Ordinance. The registration is less offending, sophisticated, British styled name for the permit and it is found to be in use in many US medical laws. This legislation puts aside such sophistry, and makes clear the states intention to regulate the medical field in the name of public interest.

The owner of a NH is required to make an application for permission to establish NH with a Rs. 100 fee if it has inpatient facility or with Rs. 10 if it does not have inpatient facility.

Inspection for permission: The inspection is mandatory in order to grant permission. This is made absolutely clear. While the Maharashtra and Delhi Acts gives power to the local authority to appoint any representative for affecting inspection, the Karnataka Ordinance makes it specific status of such representative to be appointed by the competent authority. Accordingly, no office below the rank of Class I Medical Officer of the Health department can do the inspection.

Further, the purpose of inspection is made clear. The said inspector would verify the facilities and staff at the NH. In order to assess the findings of the inspection, the rules prescribes the minimum standards for the facility and the minimum qualifications for various categories of staff and their numbers.

The permission is granted only if the prescribed standards for the facility and the staff are satisfied by the NH.

The permission given in the prescribed Form B will be conspicuously displayed in the premises of the NH.

Conditions for permission: However, satisfying the prescribed standards is not sufficient. The permission is subject to acceptance of four conditions laid down in the rules. (1) The private NH shall implement the national or state health programme as laid down and communicated to it by the competent authority or department. (2) It shall maintain the registers prescribed by the competent authority or department. (3) It shall furnish such reports and returns as may be specified by the competent authority or department to such authority on such dates as may be specified from time to time. (4) It shall implement such other programmes and directions and furnish such information to such authority and on such dates as may be specified from time to time by the competent authority or department.

While the purpose of bringing the private providers under the purview of national and state health programmes is laudable, the conditions laid down and the manner of it is undoubtedly problematic. These conditions have a streak of authoritarianism. They give unspecified far-reaching powers to faceless bureaucrats and many of the points are left so unambiguous to be invariably misused. Thus, while there is nothing wrong in reasonable conditions, they should be specific, unambiguous and the power to the bureaucracy clearly circumscribed. This was perhaps the greatest drawback of this dead legislation.

Inspection:

The rules prescribe the inspection of NH once in six months. The inspection, as stated earlier, is affected by the competent authority itself or on its behalf by a Class I medical officer of the department. The rules fixes one months time within which the report of inspection and the direction of competent authority to be communicated to the concerned NH.

Further, the NH is given one month to comply with the directions and make report of the compliance to the competent authority. The fees charged for the permission is termed as annual inspection fee.

Appeal:

Interestingly, the law, which makes a department of the state government competent authority for implementation of the Act, also makes the state government the appellate authority

Information to public:

On two counts the Rules seek to keep people or consumers informed. Firstly, it makes compulsory for the NH to conspicuously display the permission of the competent authority. Secondly, it makes it mandatory for the NH to keep a copy of the rules at a conspicuous place in the NH. This is a very important, though insufficient provision. Since the Rules contain minimum standards for the facility and the staff, and more importantly upper limit of the fees that can be charged, the availability of them in the NH at a conspicuous place is very important and useful for the consumer. However, the rules do not lay down any mechanism for the redressal of consumers' grievances.

STANDARDS:

Sections 3 and 4 of the Rules, the first two sections after preliminaries of Title and Definitions, are on Standards, giving an impression that setting standards and the ceiling on fees were the chief objectives of the Ordinance.

The Section 3 on standards is definitive. It says "Every private NH shall confirm to and maintain the standards specified in Schedule I & II" of the Rules. Thus, the standards and ceiling on fees were inseparably linked to the permission for establishment and running a private NH. The Schedules I & II therefore provide us a glipse into the thinking of our legislature and policy makers on affecting standardisation of the private NH. Though the Bureau of Indian Standards has done remarkable work, this is evidently the first legislative exercise of its kind for standardisation. We have here analysed these schedules keeping that in mind.

Schedule: 1: Standards prescribed for the private NH with in-patient facility:

The Standards in this schedule are divided into three sections: (A) Staff, (B) Accommodation and (C) Facilities.

(A) Staff: The first provision it makes is on the number and availability of registered medical practitioners. The bed doctor ratio recommended is as follows:

Bed Strength	Minimum Number of Medical Practitioners
Below 25	Two
25-50	Four
50 and above	At the rate of one for every 20 beds beyond 50 beds

For availability of doctors at the NH, the rules attach two conditions: (1) A doctor shall be available on the premises of the NH all the time for attending emergency calls, and (2) in a NH providing specialist services, there shall be available on call at least one registered medical practitioner possessing recognised specialist qualification in that speciality.

Second provision is on Nurses. According to the rules, all nursing personnel should be qualified and registered with the Nursing Council. It does not make the presence of trained nurse mandatory, thus allowing either registered trained nurse or the auxiliary nurse to work at the NH. The rules specify nurse beds ratio, which is I nurse or ANM for 10 beds.

Third provision relates to other paramedics, all must have recognised qualification. In all NHs having facility, availability of at least one paramedic related to such facility is made mandatory. The paramedics listed are pharmacist (if there is a drug store). X-ray technician (X-ray facility), lab-technician (laboratory) and physiotherapist (physiotherapy).

Fourth and last provision relates to the number of attendants to look after patients, cleanliness and sanitation. The ratio given is one attendant for every six beds.

(B) Accomodation: The minimum floor space required for each aspect of the function has been codified in the following manner in this part of the schedule:

Category	Minimum Provision
1. Waiting room	100 sq.ft (9.2 sq. mtrs)
2.Examination-cum-Prescription room	100 sq.ft. (9.2 sq. mtrs)
3. Operation theatre	225 sq.ft (29.7 sq. mtrs)
4. Labour room	150 sq.ft (18.8 sq mtrs)
5. Ward	60 sq.ft (5.6 sq. mtrs) per bed
6. Lavatory	1 for OPD, Additional 1 for every 10 beds
7. Duty doctor's room	One
8. Nurses' station	One for each group of beds.

(C) Facilities: There are seven categories of minimum standards having details of facilities for each in the Rules:

(1) Potable water: Continuous supply of wholesome potable water is considered must in the Rules. The quantity of 225 litres per per day is specified. However, the quantity per day id not linked to the number of beds or average bed occupancy.

(2) Lighting and ventilation: This is the only provision where no specification is done. The Rules state in general that there should be proper lighting and ventilation.

(3) Routine laboratory examinations: The NH with in-patient services are required to have facility for the routine laboratory examination of Blood (Haemoglobin, complete blood count) Urine (albumin, sugar, microscopy) and stool (ova, cyst, microscopy).

(4) Life saving drugs: Here the drugs are specified but not the quantity. For the later it is stated in general they they should be available in adequate quantity. The drugs specified for: emergency use are: corticosteroids, vasopressors, oxygen, antibiotics and IV fuilds.

(5) Beds and bedside facilities for each patient: As per Rules each in-patient must be provided with the following minimum furniture and linen, and in addition certain items of then should also be available in reserve:

Item	Minimum number per patient	Minimum number in reserve per patient.
1. Cot with mattresses	One	-
2. Bedside locker	One	-
3. Chair	One	-
4. Stool	One	-
5. Blanket	One	-
6. Bed sheets	Two	Eight
7. Pillow	One	-
8. Pillow cases	One	Two
9. Counterpane	One	One

(6) Operation theatre (OT): The provision made for the OT are not ftilly specified, they are general provisions. The Rules say that the OT should be safe and equipped with (a) operation table and instruments, (b) anaesthetic equipments, (c) resuscitation equipments and (d) sterilisation equipments.

(7) Labour room (LR): The Rules state that, "the labour room, if provided, shall have an obstetric table."

Schedule: II: Standards prescribed for NHs without in-patient facility:

The standards for the NHs providing only Outpatient services are in four categories:

(1) Cleanliness: This is very general. The rules say that "the premises of the NH shall be clean". Thus no specific standards for cleanliness are formulated.

(2) Privacy: There is no specific standard for norms of maintaining privacy given. It is tated that "there shall be adequate provision in the NH for maintenance of privacy during examination" Surprisingly, not even a general statement like this is made on privacy standards for the NH with in-patient facility.

(3) Operation theatre (if provided): Here too no specific standards formulated. It says in general that the OT "should be safe and equipped with operation table and instruments, anaesthetic equipment, resuscitation equipment and sterilisation equipment".

(4) Paramedical staff: The number and availability of paramedical staff is linked to the provision of the related services. Accordingly, one pharmacist is provided if there is a drug store maintained by the NH, one X-ray technician for X-ray facility, one laboratory technician for the laboratory facility and one physiotherapist for the physiotherapy facility.

FEES:

Section 4 of the Rules states in a definitive way, "No NH shall charge or collect fees for medical treatment given at rates higher than those specified in Schedule III." Thus, the Ordinance clearly tried to regulate or control all aspects of fee or price of medical care in the private sector The Ordinance established a principle that our legislatures have a statutory authority to control the price of medical care. It could not have been different as there are many commodities which are price controlled. Lastly, it provided an upper limit or ceiling to the price of various medical services that could be charged.

The Schedule III: Maximum fees prescribed for medical treatment in private NHs:

The Rules do not define the term "medical treatment". The fee seems to mean charges for a wide range of medical care, specified in great detail in the Schedule.

The medical care is divided into four categories:

(A) Treatment and operations: This section is having the longest list. It has listed 348 (three hundred forty eight) items covering treatment and operation and almost all specialities are covered.

The maximum chargeable fee ranges from Rs. 9 (nine) for group speech therapy to Rs. 3300 (three thousand three hundred) for total hip replacement.

(B) Consultation fees: The consultation fee is divided into two categories

I. The specialist consultation fee: The specialist is defined as a practitioner possessing a post- graduate or diploma in addition basis medical qualification. The upper limit of fee for first consultation is fixed at Rs. 30 (thirty) and for the subsequent consultation, if done within a period of two weeks at Rs. 10 (ten).

II. Non-specialist consultation fee: The upper limit is fixed at Rs. 5 (five).

(C) Pathological and laboratory investigations and X-ray charges and charges for other procedures: This section gives upper limit of charges for over 150 items. The range being from Rs. 3 (three) for urine sugar examination and other, to Rs. 500 (five hundred) for angiocardiography.

The investigations are divided into: (1) Chemical pathology , (2) Haematology, (3) Histopathology, (4) Miscellaneous, (5) Investigations done in microbiology department, (6) Other procedures (includes only ECG), (7) Physical therapy, (8) X-ray with report, (9) Radioisotope investigations.

(D) Accommodation charges: This is for in-patient. The upper limit of charges is done in the following manner.

(1) Single room (specifications: Minimum floor area 100 sq. ft. or 9.2 sq. mtres, attached bath and lavatory): Rs. 30 per day. If in this single room, an extra bed for attendant is provided, then the upper limit of fee is Rs. 40 per day.

(2) Two beds in one room: (specification: Minimum floor space 120 sq. ft or 11.2 sq. mtres, attached bath and lavatory): Rs 15 per bed per day.

(3) Three bed and more (specification: 60 sq. ft. or 5.6 sq. metres per bed, need not have attached bath and lavatory): Rs. 10 per bed per day.

8. NEGLIGENCE IN MEDICAL CARE AND THE LAW

As we discussed in the previous chapters, three agencies providing health care to people, namely, the government, the health care professionals and hospitals / nursing homes are either not specifically regulated by any legal regulations to ensure delivery of minimum level of quality care by competent health professionals, or if there are laws, they are not properly implemented. In the context of over three fourth of health care being in the unregulated private sector and governed by the vagaries of unregulated market, what are the remedies available to people or the patients? Obviously, there is no remedy available if the patient goes to the government provider not having essential supplies and/or even a qualified health professional, to treat him or her free. In the event of the patient not having money to buy the necessary supplies for Treatment or transport to reach a government health facility, nothing in the law would provide him/her any remedy as there is no right to minimum health care. On the other hand, in order to come "under treatment" of a private provider, the patient need to have purchasing p6wer. If s/he does not have requisite purchasing power, the law cannot help at all.

However, after the patients are taken for treatment in the government and private sectors, as we showed in previous chapters, due to ineffective regulations, there is no guarantee that the health professionals are always properly qualified and if qualified, are actually competent; and that the hospitals and nursing homes meet the reasonable scientific standards of care. Indeed, this function is left to the market. That is, if the patient does not like it, s/he can go to another provider. However, after s/he has accepts to undergo treatment and something goes wrong, the law comes into picture or that there is legal remedy available. This legal remedy is not made available through any specific legislation, but is available through what is called tort law.

In this chapter we turn to the legal remedy which is essentially influenced by the ideology of market: the malpractice litigation. To what extent such legal regulations are actually effective in the Indian situation? Are people using them as widely as feared by doctors in recent times? What are the likely consequences of leaving the regulation of health care to tort laws and malpractice litigation for a country like ours? In answering these questions, we have gone into details of the tort laws, negligence, done case studies of some patients who got involved in such litigations and then compared the situation with that in other countries.

Negligence and Torts:

Medical negligence litigation is a response to the following types of questions.

What are the rights of patients vis-a-vis the doctors and hospitals?
What if the doctor wrongly diagnoses a disease?

What is the level of competence expected of a doctor?
Does a doctor have to take the consent of the patient before an operation?
If many doctors have handled a patient which of them is ultimately liable?

The common issue in all this is the patient's allegation that the doctor has been negligent.

Medical negligence is a branch of the law of negligence, which in turn is a branch of the law of Torts. The Tort law is not based on any act of parliament. It is mainly a judge made law developing over the years through changing judicial decisions. It is not possible to define Torts but broadly speaking tort is a wrong done by one person to another for which the law provides a remedy. The idea is to monetarily compensate the victim rather than punish the offender, as would be the case in criminal law. It includes disparate events such as car accident, injuries due to emission of poisonous gas, doctor's negligence causing death of a patient, defamation of a person, compensation for injuries suffered by a wife at the hands of her husband, etc. The motives of the offender are not very relevant. The focus is on the victim.

A person is said to be negligent when s/he acts without due care in regard to the harmful consequences of his/her action. When we say that a person has been negligent we are saying that s/he acted in a way that s/he ought not to have acted. This assumes that we know how s/he ought to have acted. The way in which we consider that s/he ought to have acted is the norm or standard which entitles us to condemn the person for being negligent when s/he fails to comply with the standard.

The tort of negligence is made up of the following components;

1. A duty or obligation recognised by the law requiring the person to comply with certain standards of conduct for the protection of others against unreasonable risks. Initially charitable hospitals used to claim that they could not be held negligent as they had no duty to take care of patients since they were not charging them. Now of course the courts always disregard such defence.

2. A failure on the part of the pa-son to conform to the standard required, what is known as a 'breach of duty'.

3 A reasonably close casual connection between the conduct and the resulting injuries.

4. Actual loss or damage resulting to the other.

So negligence ultimately is a matter of risk, that is to say, of recognisable danger or injury. Persons are supposed to meet with certain standards of conduct. This standard is supposedly based on what society demands of its members, rather than upon the actor's personal morality. A failure to conform to the standard is negligence, even if it

is due to clumsiness, forgetful nature, an excitable temperament or even sheer ignorance. In other words, the state requires a person not to be awkward or a fool.

In negligence, the actor does not desire to bring about the consequences which follow nor does s/he know that they are certain to occur or believe that they will. There is merely a risk of such consequences sufficiently great for a 'reasonable person* in his/her position to anticipate them and to guard against them. Risk can be defined as a danger, which is apparent or should be apparent, to one in the position of the actor.

Nearly all human acts, of course, carry some recognisable or remote possibility of harm to another. No person so much rides a horse without some chance of a runaway nor does any surgeon performs an operation without some chance of himself suffering a heart attack and messing up the operation. Those are of course, 'unavoidable accidents' for which there is no liability. As the gravity of the possible harm increases, the apparent likelihood of its occurrence needs be correspondingly less to generate a duty of precaution. Thus the standard of conduct which is the basis of the law of negligence is normally determined upon a risk benefit form of analysis by balancing the risk in the light of the 'social value' of the interest threatened, and the probability and the extent of the harm, against the value of the interest which the actor is seeking to protect and the expedience of the course pursued.

Professional Negligence:

Negligence is not mere "neglect" or "carelessness" but is the failure to take such care as the circumstances demand. Medical negligence is defined as want of reasonable degree of care and skill or wilful negligence on the part of a medical practitioner in the treatment of a patient with whom a relationship of professional attendant is established so as to lead to bodily injury or to the loss of life. Thus there has to be failure on the part of the medical practitioner to act in accordance with prevailing medical standards which are being practised by a reasonably competent person practicing the same art.

Until now what we have talked about is the minimum standard below which the individual is not permitted to fall. But if a person in fact has knowledge, skill or even intelligence superior to that of the ordinary person, the law will demand of that person's conduct to be consistent with it. Professional persons are not only required to exercise reasonable care in what they do, but also a standard minimum of special knowledge and ability.

Let us look at how in practical situations, the law applies to doctors. A doctor may, of course, contract to cure a patient, or to accomplish a particular result, in which case, he may be liable for breach of contract. This is not, however what generally happens. In the absence of such express agreement, the doctor does not warrant or insure a correct diagnosis or a successful course of treatment and a doctor will not be liable for an honest mistake of judgement where the proper course is open to a reasonable doubt. But by undertaking to render medical services, even though gratuitously, a

doctor will evidently be understood to hold himself out as having standard professional skill and knowledge. The formula which is used is that the doctor must have and use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing, and a doctor will be liable if harm results because he does not have them. Sometimes, this is called the skill of the 'average' member of the profession, but this is clarity misleading. For only those in good professional standing are to be considered, and of this it is not the middle but the minimum common skill which is to be looked to. If the doctor claims to have greater skill than this, as when the doctor holds himself out as a specialist, the standard has to be modified accordingly.

Of course, there are areas in which even experts differ. Where there are different schools of medical thought and alternative methods of acceptable treatment, it is held that the dispute cannot be settled by the law and the doctor is entitled to be judged according to the facts of the school the doctor prefers to follow. This does not to mean that any quack or a crackpot can let himself be known as a 'school' and so apply his individual ideas without liability. A 'school' must be recognised one within definite principles and it must be the line of thought of a respectable minority of the profession. In addition, there are minimum requirements of skill and knowledge, which anyone who holds himself out as competent to treat human ailments is required to have, regardless of his personal views on medical subjects.

The test to determine whether an act or omission amounts to medical negligence was laid down in Bolam Vs. Friem Hospital Management Committee [(1957) 2 All. E. R. 118]. Mr, Justice McNair said, " In the case of a medical man, negligence means failure to act in accordance with the standard of a reasonably competent medical man at the time. That is a perfectly accurate statement so long as it is remembered that there may be one or more perfectly proper standards and if a medical man conforms with one of those proper standards, then he is not negligent."

Since judges/juries are essentially lay people, they are held to be normally incompetent to pass judgement on questions of medical science or technique and so only in certain types of cases findings of negligence are given in the absence of expert medical evidence. Normal reluctance of doctors to testily against co- professionals came in the way in the US and the UK and is also a big hurdle at present in India. Now of course, in the US and the UK more and more doctors come forward to give evidence on behalf of patients. One doesn't know when the situation will change in India. Also, where the matter is regarded as within common knowledge of the lay people, as when the surgeon saws off the wrong leg or where injury is caused to a part of the body not within the operative field, the judges often infer negligence without expert evidence.

The cumulative effect of all this is that the standard of conduct becomes one of 'good medical practice' i.e. what is customary and usual in the profession. This, of course, gives medical profession a privilege denied to others, of setting their own standards of conduct, merely by adopting their own practices, except in certain cases like in the

cases of sponges left in the patient's abdomen after an operation where the task of keeping track of them has been delegated by the surgeon to a nurse. Though this was and is still a routine practice, the doctor was found to be negligent.

An aggrieved patient or relative can file a case for medical negligence in the civil court or criminal court. Civil negligence is a form of negligence in which a patient brings an action for damages in a civil court against her/his medical attendant, who owed her/him a duty in tort or care and such person had suffered injury in consequence of negligence or unskilled treatment. The three essential conditions necessary in the case of civil negligence are:-

the nature of injury suggests by common knowledge or expert evidence that without negligence it does not occur, (ii) the plaintiff must not contribute to his own injury, and (iii) the defendant must be in exclusive control of instrumentalities.

The burden of proving negligence rests on the plaintiff. It is very difficult for the plaintiff to directly prove medical negligence and therefore often circumstantial evidence is the basis for concluding negligence. The extent of liability of the medical practitioner is not decreased by the fact that s/he treated her/his patient gratuitously in a charitable hospital or that payment was made by a person other than the patient her/himself for the medical service rendered.

The cause of action for civil negligence against professionals is to sue in tort or breach of contract. The distinction between contract and tort is that in contract the duty arises from the agreement of the parties and in tort the duty is independent of agreement and is imposed upon the parties by law. There is on the part of the doctor an implied warranty that he is of skill reasonably competent to perform the task he undertakes.

Lastly, it must be kept in mind that the law of medical negligence is tilted in favour of and is very considerate towards the medical professional. Previously the courts were hesitant in holding the medical practitioner liable for negligence. This comes out clearly from the judgements given in the earlier malpractice cases in the developed countries as well as in India.

The first reported English case on medical negligence is Rich Vs. Pierport (1862) 176 E. R. 16] The case against the doctor was that he did not use due skill and care whilst attending upon a patient and that the doctor improperly administered a certain drug. The learned Judge observed that a medical man was certainly not answerable merely because some other practitioner might have shown greater skill and knowledge. Such dominant trend in court judgements continued for long time in England. For instance, in Roe Vs. Ministry of Health [(1954) 2 All. E. R. 131], Lord Justice Denning said, "These two men have suffered such terrible consequences that theirs is a natural feeling that they should be compensated. But we should be doing a discredit to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own

safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patients at every point, but we must not condemn as negligence that which is only a misadventure." Several other judgements during the same period held likewise and were tilled in favour of the medical professional. The courts were of the opinion that it was a very serious matter to charge a medical practitioner with want of skill and competence in treating the patient and that much stronger and much better evidence was necessary before a charge of medical negligence can be brought home to a medical practitioner. We with see that this trend has changed, but before we analyse the change, let us document similar trend exhibited by the Indian courts.

The Bombay High Court in Amelia Flounders Vs. Dr. Clement Pereira [unreported] and the Lahore High Court in V. N. Whitamore Vs. R. N. Rao [AIR 1935 Lahore 247] held that the Plaintiffs had failed to establish want of competent care and skill. These two cases were the first Indian cases dealing with medical negligence. The details of the Lahore High Court case decided in 1935 was something like this. Mr R.N. Rao, a lawyer, suffered from high fever and sores on his face. Dr. Whitamore, the Civil Surgeon, treated him. He diagnosed the disease as syphilis and gave him treatment. Later Dr..Rao suffered from gangrene and had to have his fingers amputated. His eyesight was affected and he lost his strength. He never had any syphilis and he was informed that he had contacted peripheral neuritis because of a mistaken injection of arsenic.

The court, however, did not find the doctor guilty. The reason given was that though the diagnosis was wrong, specific carelessness was not proved. The court adopted a reasoning which would be totally unacceptable today. It did not go into the question as to whether the doctor had performed the required tests before concluding that there was syphilis. Neither did it try to a answer the question as to what caused the gangrene.

Another important case in this category was decided by the Bombay High Court in 1975 (Phillips India Ltd. Vs. Kunju Punnu, AIR 1975 Born. 306). This case read like a doctor's apology. Philips India had appointed a doctor to give treatment to the employees. One employee contacted smallpox and died. The doctor had treated him for venereal disease. The court felt that there was a genuine error of judgement and since the particular variety of small pox was fatal, the doctor any way could not have done much. The problem with the case is not that it exonerated the doctor, especially considering the peculiar facts of the case, but the extent to which it sought to protect doctors. The court expressed the view that negligence for doctors should be interpreted much more narrowly than negligence of others, i.e. the doctor has to be placed on a high pedestal and held to be negligent only if it is totally unavoidable. The important point decided by this case, however, was in holding that if the doctor had been proved to be negligent, the company which employed him would also automatically be negligent.

Of course, this case is not likely to have any impact on subsequent cases, but still, it shows the attitude of the judges.

Changing Trends:

In one of the earliest decided cases, an English court felt that the surgeon was liable as he had acted contrary to the known rule and usage of surgeons. What happens if the patient is injured because of the omission to carry out an available test, which is not generally conducted by doctors for such patients? In 1974 an American Appeal Court was faced with this issue. Barbara Helling suffered from primary open glaucoma. This is a condition of eye where there is an interference in the nourishing fluid's flow out of the eye. There can be a resultant loss of vision. The disease has few symptoms and in the absence of 'pressure test', is often undetected till irreversible damage is done.

Helling contacted two ophthalmologists, Carey and Laughlin, at that time believing that she was suffering from myopia (short-sightedness). From 1959 to 1968 she consulted these doctors, who fitted contact lenses and believed that irritation caused in her eyes was because of complications associated with the lenses. For the first time in 1968 they tested the patient's eye pressure and field of vision. This indicated that she had glaucoma. By that time the patient, who was 32, had essentially lost her peripheral vision and her central vision was reduced. She filed a case for damages.

The doctors argued and proved that the standard of the profession did not require the giving of routine pressure test to persons under the age of 40 as the incidence of glaucoma is I out of 25,000 persons under the age of 40. They argued that since they had acted in accordance with the standard practice of the profession they had acted with reasonable prudence. The court, however, disregarded this defence. The judges held: "in most cases reasonable prudence is in fact common prudence, but strictly it is never its measure. A whole calling may have unduly lagged in the adoption of new and available devices. Courts must in the end say what is required: there are precautions so imperative that even their universal disregard will not excuse their omission". The Court felt that despite the fact that a pressure test was not used generally by ophthalmologists, the doctors ought to have used it. Barbara received compensation.

The importance of the case lies in the fact that the standard of care required of the doctors is widened. Normally, of course, the standard adopted in the profession would be acceptable as the standard required of each doctor. But this case for the first time obliged doctors to conduct certain known tests even if they were not being conducted in the profession generally.

This case created a storm in the USA. Attempts were made through courts and legislature to change the law laid down by the case, but ultimately they have proved to be futile. However, the application of this case is only confined to a narrow field of

possibilities and that the rule of 'general practice' within profession is still widely applied.

There are not many successful Indian cases to rely on. However, two may be cited. The case, Dr. Laxman Balkrishna Joshi Vs. Dr. Trimbak Babu Godbole [AIR 1969 S.C. 128] was decided by the Supreme Court in 1969. Anand met with an accident on the beach at Palshet in Maharashtra which resulted in the fracture of the femur of his left leg. The only treatment the local physician gave was to tie wooden planks on his legs for immobilisation. The following day he advised removing Anand to Poona for treatment. He also substituted splints for the planks. After that, in a taxi, Anand was shifted to Poona. Dr. Joshi got him screened and found that he needed pin traction. He was then taken to Dr. Joshi's hospital. Dr. Joshi asked his assistant. Dr. Irani to give Anand two injections of morphia and hyoscine HB at 1/2 hour interval. Dr. Irani gave only one injection. Anand was then taken to the X-Ray room, and after taking two X-rays removed to the operation room. After about 1/2 hour when the treatment was over, he was shifted to the room he was allotted. On an assurance given by Dr. Joshi that Anand would be out of the effect of morphia in 1 1/2 hours, Anand's father went back to his village. Anand's mother remained with him. After about an hour, she found that Anand was having difficulty in breathing and was coughing. The doctors were called. Dr. Irani, gave emergency treatment up to 9.00 p.m. when the boy died. Dr. Joshi issued a certificate saying that Anand had died of embolism.

Dr. Joshi was sued. Anand's father contended that Dr. Joshi did not perform the essential preliminary examination of the boy before starting his treatment and injecting morphia. It was also alleged that while putting the leg in plaster manual traction was used, using excessive force with the help of three men though such traction is never done under morphia alone, but under proper general anaesthesia. Dr. Joshi in his reply denied the allegations by saying that no general anaesthesia was given considering the exhausted condition of patient. It was decided to immobilise the fractured femur by plaster of Paris bandage and no excessive force was used. However, on evidence the court felt that Dr. Joshi was negligent. It came to the conclusion that it was due to shock resulting from reduction of fracture attempted without taking the elementary precaution of giving anaesthetic to the patient.

Speaking about the duties of doctors, the court repeated the British and American law saying "The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient, owes him certain duties, viz, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of these duties gives a right of action for negligence to the patient".

Another case involved the government services. In A.S. Mittal Vs. State ofUttar Pradesh [(1989) 3 SCC 223], an Eye Camp was organised and minor and low risk surgery was carried out on a number of cataract patients. Unfortunately, the operated

eyes of the patients were irreversibly damaged due to post-operative infection. A Public Interest Litigation was filed in the Supreme Court. It was held that the officers of the government had committed serious breaches of duty in sanctioning permission for the conducting of the Eye Camp without ensuring strict compliance with the conditions prescribed in the guidelines laid down by the government and in not overseeing the satisfactory and safe functioning of the camp. The Supreme Court directed the State Government to pay Rs. 12,500/- to each of the victims in addition to Rs.5,000/- already paid as compensation.

Criminal negligence:

In order to punish a negligent doctor the patient or relative has to seek redressal in a Criminal Court. Criminal negligence is negligence which amounts to a crime. To render a medical practitioner criminally responsible for the death of her/his patient, it must be established that s/he showed such disregard for the life and safety of the patient as to amount to a crime deserving punishment. In criminal negligence the negligence should be gross. Civil liability exists for a lesser degree of negligence and criminal liabilities is reserved for gross aberrations. Therefore a doctor acquitted by the criminal court might become liable on the same set of acts in a civil action based on medical negligence.

A medical practitioner is liable for the death of a patient under section 304- A of the Indian Penal Code, 1860. The Section 304-A says, "Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both." This section deals with homicide caused by negligence. A person would be held guilty of commission of an offence under this section if it is proved that a rash and negligent act was the direct cause of death. Contributory negligence of the victim does not absolve the medical practitioner of his/her liability under Section 304-A.

For criminal negligence the medical practitioner will be prosecuted by the police and charged under section 304-A of IPC in a criminal court with having caused the death of his/her patient by doing a rash or negligent act not amounting to culpable homicide if the death was the result of gross negligence, gross carelessness or gross ignorance displayed by him during the administration of an anaesthetic, performance of an operation or any other treatment. Before a medical practitioner can be held criminally responsible for the death of her/his patient, the prosecution must prove all matters necessary to establish civil negligence except pecuniary loss and in addition must prove negligence or incompetence on her/his part and showed such disregard for the life and safety of the patient as to amount to a crime against the state and deserving punishment.

The question of criminal negligence often arises in a criminal court when the defence counsel attributes the death of an assaulted person to the negligence or undue interference of the medical attendant in the treatment of the deceased. However, it

must be kept in mind that the Section 92 of the Indian Penal Code, 1860 protects a medical practitioner against any harm caused to a person in good faith.

In Juggankhan Vs. State of Madhya Pradesh [AIR 1965 S.C. 831], a homeopathic doctor was held guilty of committing an offence under Section 304-A when the patient collapsed due to the doctor prescribing medicine without contemplating the reaction such medicine could cause

A person is guilty of gross negligence if he gives medical treatment when he is unqualified to do so. In Dr. Kharshaldas Pammandas Vs. State of Madhya Pradesh [AIR 1960 M.P. 50], the court observed, "where a practitioner is utterly ignorant of the science of medicine or practice of surgery, then favourable view of his conduct in giving any treatment prescribed in that science cannot be taken. His ignorance alone would make his act of giving treatment rash and negligent."

In Dr. V. Rugmini Vs. State of Kerala [1987 Cr. L. J. 200], a pregnant woman in labour pain was examined by the doctor treating her saying that everything was normal. The woman delivered a cyanosed baby and subsequently both the mother and the child died. A case was registered under Section 304-A of IPC. The doctor moved the High Court to quash the First Information Report. The court held that the case disclosed sufficient averments of an offence committed under Section 304-A of IPC especially as the doctor had suppressed relevant information from the patient and/or relatives and had not suggested specialised treatment.

Contributory negligence and vicarious liability:

Contributory negligence is when the cause of the harm complained is the unreasonable conduct or negligence on the part of the patient although the attending doctor was also negligent e.g. the patient refuses to take the suggested treatment. The doctor's negligence is not the direct and proximate cause of the harm suffered by the patient. The doctrine of contributory negligence is not recognised as a defence in an indictment of criminal negligence but is a good defence in cases of civil liabilities and is taken into consideration by the court while awarding damages to the plaintiff.

Vicarious liability: A medical practitioner may be held responsible civilly, but not criminally, for a negligent act of some third party such as a nurse, compounder, student or assistant employed to carry out nursing and medical duty of her/his patients if the act was committed in her/his presence and to which he

The principle underlying vicarious liability is that "as a general rule a man is responsible for any wrongful act done by his agent or subordinate provided such act is within the reasonable scope of their employment." In deciding such cases the courts are inclined to depend upon the practice of the institution as to what comes within the scope of a nurse's duties and to limit the surgeon's liability for those matters over which s/he has direct control. Often it is not possible to point out the person whose

negligence led to injury. The medical practitioner is liable for the negligence of an assistant employed by him.

Hospital Liability:

A question of immediate significance is whether a hospital can be made to pay for negligence of doctors, nurses and other staff. This is an issue of great importance in India. Many times it is not possible to point out the person whose negligence led to injury. Take the example of a patient who is given saline by a number of doctors and nurses from time to time. A particular needle may not be sterilised causing gangrene. It is not possible to know who exactly was negligent. Can one then sue the hospital? Or many times it may so happen that the negligent staff member does not have means to pay. Can one sue the hospital and recover the compensation?

The most important American case on this point was Darling vs Charleston Community Memorial Hospital decided in 1966. In November 1960, Darling, 18 years old broke his leg while playing college football. He was taken to emergency ward of Charleston Hospital and treated by Dr. Meroander, who applied traction and placed the leg in a plaster cast. Soon after, Darling was in great pain and his toes which protruded from the case, became swollen and dark in colour. His condition kept on worsening and ultimately the leg had to be amputated.

As to the question whether there was negligence or nor, the court held that the nurses had not checked sufficiently, and as frequently as necessary, the blood circulation in the leg. Skilled nurses would have promptly recognised the condition and would have known that it would become irreversible in a matter of hours.

The question was whether the hospital was liable. The judges held: "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and patients, but undertakes instead simply to procure than upon their own responsibility, no longer reflects the fact. The present day hospitals, as their manner of operation plainly demonstrates, do far more than fiirnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting fees for such services, if necessary, by legal action. Certainly the person who avails himself of hospital facilities expects that the hospital will attempt to cure him not that the nurses and other employees will act on their own responsibility" The hospital was made to pay damages.

The Darling case became a landmark decision in medical malpractice claims as it places a direct responsibility on the hospital for the maintenance of an acceptable standard of care for patients. Subsequently, the scope of even this decision has been widened and charitable hospitals have also been held to be responsible.

Is the hospital liable if the patient's infection is traced to blood products supplied during his operation? In a 1970 Illinois state case, the hospital was held to be strictly

liable for supplying contaminated blood. A hospital will also be liable for negligence of any honorary doctors or specialists it calls, but not for private doctors called by the patients themselves. Hospitals, in same case have been held guilty even when their employees have acted in direct contradiction of the hospitals' instructions or prohibitions causing injury.

In India, previously a hospital or a medical practitioner would not admit or treat an injured patient without a police report. The Supreme Court has held in Pt. Parmanand Katara Vs. Union of India [AIR 1989 S.C. 2039] that there is no legal impediment for a hospital or medical professional when called upon or requested to attend to an injured person needing medical assistance immediately. This duty is equally shared by the police, the connected persons and those who see such an incident or accident. The primary duty of the hospital and medical practitioner is to save the life of the injured in the case of an emergency.

Strict Locality Rule:

The standard of care expected of doctors is generally speaking that prevalent in the profession. They are not only required to perform tests generally performed, but also to be informed sufficiently about the new developments in the field.

One of the most debated issues in the US and UK arose out of a presumption that the rural and small time practitioners would be less adequately informed and equipped than their big city colleagues. To adjust to this, the courts came out with a theory that there could not be any national standard of care but the standard varied from locality to locality. They applied the strict locality rule which meant that the standard of care expected of doctors depended on the general standard of that particular locality. However, in recent times this rule has been given up and national standard applied on the basis that "new techniques and discoveries are available to all doctors within a short period of time through medical journals, closed circuit television, special radio networks for doctors, tape recorded digests of medical literature and current correspondence course."

This situation is prevalent only in developed capitalist countries. In backward countries like India with uneven development, it is very likely that when cases come up, the strict locality rule will be applied.

Res Ipsa-Loquitor:

Ultimately it is for the patient to prove that it was negligence which caused her/his injuries. Many times it becomes difficult to do so for varied reasons like hiding of information by the doctors etc. What happens in some cases, however, is that after presenting all evidence, though the negligence is not proved directly, it is still pretty obvious that the patient could not have suffered injuries except through negligence. In such cases the legal doctrine of 'Res Ipsa-Loquitor" or 'the thing speaks for itself is applied. Negligence is presumed to have been proved and the doctors held liable.

In a case decided in an American Court in 1975, a patient Anderson was admitted to hospital for a back operation. During the operation, the tip or cup of a forceps like instrument (angulated rongekur) broke off while it was being manipulated in the patient's spinal cord. It could not be recovered and the patient suffered permanent injury. Anderson sued the doctor, the hospital, the manufacturer and the distributor. Each tried to push the blame on the other and it could not be proved as to whose negligence had led to this complication. It was not established whether the rongekur broke because of manufacturing defect, certain problems during transit or due to the doctor's negligence. If it was merely a case of determining negligence from amongst the hospital staff and doctors, then even without establishing who exactly was negligent, the hospital could have been saddled with damages. Here of course, the hospital was saying that it was not the neglect of staff or doctors which caused the rongekur to break but that of the manufacturer or dealer.

It was just not possible to establish what caused the breakage. The court, however, came to the rescue of the patient and observed, "In the type of case we consider here, where an unconscious or helpless patient suffers an admitted mishap not reasonably foreseeable and unrelated to the scope of surgery (such as cases in which foreign objects are left in the body of the patient), those who had custody of the patient, and who owe him a duty of care as to medical treatment or not to furnish a defective instrument for use in such treatment, can be called to account for their default. They must prove their in-culpability or else risk liabilities for injuries suffered". All of them were held jointly liable.

The doctrine of Res Ipsa-Loquitor has been extensively used in ' swab cases' where after the operation, an instrument is left inside the patient's body. It has also been used for other types of cases, for instance in the Canadian case of MacDonald vs York Country Hospital Corporation, the patient was admitted for treatment of fractured ankle and left with an amputated leg. Heavy damages were awarded to MacDonald despite there being no direct proof of negligence.

Misdiagnosis:

A liability will be imposed when the doctor fails to conduct tests which a competent practitioner would have considered appropriate or when the doctor fails to diagnose a condition which would have been spotted by a competent practitioner. In Langley's case, the patient had returned from East Africa shortly before the development of symptoms. The general practitioner failed to diagnose malaria and this was considered as negligence. Similarly in Tuffil's case the patient had spent many years in a tropical climate, the doctor failed to diagnose amoebic dysentry which proved fatal. This failure to diagnose was held to be negligence.

A question which arises is whether a new doctor would have the same responsibility as a seasoned doctor? The law makes no distinction in this regard. In Wilsher vs Essex Area Health Authority case, the patieriKiad been born prematurely and had

been admitted to a special unit where extra oxygen was administered to him over a long period. His eye-sight was badly affected as a result of a junior doctor's failure to monitor properly the supply of oxygen. The hospital was held to be liable.

In many cases it is a part of the duty of the doctors and nurses to predict that the patients may damage themselves as a result of their medical condition. For instance in one case the patient had been admitted to hospital after a drug overdose. Although he had known suicidal tendencies, he was not kept under constant observation and he climbed on the hospital roof and fell incurring injuries, while the two nurses on duty were out of the ward. He was awarded damages of 19,000 pounds.

Informed Consent:

One of the most rapidly growing medical malpractice litigation is in the areas of 'informed consent'. This concerns the duty of physician or surgeon to inform the patients of the risk involved in treatment or surgery.

The principle behind this is the classical bourgeois democratic ideal of individual autonomy, i.e. that every person has a right to determine what will be done to her own body and the right to have bodily integrity protected against invasion by others. Only in certain narrowly defined circumstances can this integrity be compromised without the individual's consent.

Surgeons and other doctors have to provide their patients sufficient information to permit the patient to make an informed and intelligent decision on whether to submit to a proposed course of treatment or surgery. So, even if a procedure is skill-fully performed, the doctor may nevertheless be liable for an adverse consequence about which the patient was not adequately informed. Of course, the patient has to show a casual link between the nondisclosure and his/her injury by proving that s/he would not have undergone the treatment if s/he had known the risk of harm that in fact occurred. The courts believe that all patients, in retrospect, would say this and so even here they have evolved the criteria of 'reasonable patient' i.e. whether this hypothetical patient in the actual patient's place would have withheld consent to the treatment had the material risks been disclosed. This, of course, is problematic because the individual patient's characteristics are totally ignored. Slowly, the courts in the US are trying to incorporate even this subjective factor.

What risks have to be disclosed? All the material risks i.e. the nature of pertinent ailment, the risks of proposed treatment, including the risks of failing to undergo treatment, have to be disclosed. Even if the risk is a remote possibility it should be disclosed. However, unexpected risks may not be communicated. For instance, in an American case a patient suffered cardiac arrest during amniocentesis. There were no prior documented cases like this. The doctor was not held to be negligent.

Even otherwise, there are cases where the risk disclosure may be precluded by an emergency situation or the patient's incapacity. In fact in the US all states have passed

what are called 'Good Samaritan Laws' aimed at protecting doctors giving emergency roadside treatment.

The disputed issue is whether for the benefit of the patient, the doctor can withhold information from them. This happens many times when doctors feel that the patient will suffer mental shock or nervous breakdown if the risk is communicated. Such withholding is called 'therapeutic privileges'. But there is another school which believes that all information should be disclosed so that the patient can make up her/his mind in the light of all the circumstances. The courts are divided on this point.

A problem which has not arisen in the western countries but which can arise in India is if the patient is conscious and does not consent to a treatment which is necessary to save his/her life. Can forcible treatment be justified? In most of the western countries suicide is no longer a crime and so doctors cannot forcibly treat anyone. In India, of course, this question is likely to cause some problems.

The case of minors also raises a perplexing problem. Since minors are considered by law incapable of giving consent, the parents' consent has to be obtained. But what happens if a minor who is of understanding age gives instruction contrary to that of the parents? In one English case, a school girl aged 15 wanted an abortion but the parents refused to grant permission. The court held that the girl was entitled to abortion as she was capable of understanding its implications.

Nowadays, at least before surgery, a patient is normally required to sign to sign a consent form. But the patient can still prove that no consent or informed consent was taken and the doctor will then be liable to pay damages.

Consumer Protection Act, 1986

Medical negligence litigation has in the past two decades risen sharply in England and the United States. There was no corresponding trend in India but after the enactment of the Consumer Protection Act, 1986 an increase in medical malpractice litigation in India is expected.

Under the Consumer Protection Act, 1986 no court fee nor stamp duty requires to be paid by the complainant. The complainant and the procedure for filing the complaint is informal and simple. A time frame is provided in the Act within which the disposal of cases is to take place. The consumer court is a speedy, inexpensive and simple quasi-judicial machinery to adjudicate consumer disputes. There are different consumer forums in which a complaint can be filed depending on the pecuniary value of the claim; (i) District forum: claim up to Rs. 5,00,000, (ii) State Commission: claim between Rs. 5,00,000 and Rs. 20,00,000 and, (iii) National Commission: claim over Rs. 20,00,000. The complaint can be filed by the aggrieved party or a consumer organisation.

In essence, the consumer courts apply the same principles in determining medical negligence and the compensation due. The medical profession has struggled hard to get itself exempted from the purview of consumer protection act. However, the recent supreme court judgement has brought the curtain down on the legal controversy. It should also be noted that by making the access to court easy and the pronouncement of judgement faster, the consumer act has though increased number medical malpractice cases, the increase is not so remarkably high. Interestingly, the consumer courts are badly constituted, inadequately staffed, financed and supported by the government. The discharge of justice has not got speeded up as was envisaged. And in medical negligence cases, there is no sign that the consumer courts are giving liberal judgements. On the contrary, faced with technical issues and the outcry of medical profession, the consumer court in Bombay has been demanding from the complainants an opinion of independent doctor, a demand very difficult to meet as doctors are reluctant to give objective opinion on such cases.

Conclusion:

Medical malpractice is already a well entrenched litigation sphere in western countries. Though in India until now there has been precious little happening on this front, it seems that more and more medical malpractice claims are being filed since the past five years, and over the next decade or so this branch will acquire at least some significance.

The existing negligence law is not panacea. But given the circumstances, it serves a useful purpose at least to an extent to mitigate the victims and bring accountability to doctors. Also, in a country like India, where especially the poor receive extremely negligent medical treatment, extensive application of medical negligence law by people and by progressive groups can be very helpful to people and at least some way of improving health services. Also surveys in the US indicate that medical practice litigation provokes greater care at least in diagnosis.

At present, litigation in case of medical malpractice is not widely prevalent. But the trend is catching on, especially in urban areas. While litigation in itself, may not serve to wipe out malpractice, the threat of legal recourse can certainly create conditions compelling accountability on the part of the medical profession. Needless to say, the extent of utilisation of legal recourse would be pre-determined by its accessibility as well as the extent to which demystified information reaches the masses.

Politics of Torts:

A proper understanding of the rise of 'negligence law' requires an analysis of the development and rise of the Tort Law. An extensive application of tort law is found only in developed capitalist countries. Application at similar scale have not been achieved and perhaps cannot be expected in the underdeveloped countries. Let us therefore look at the causes which gave rise to tort law in developed capitalist countries.

In the earlier period, law was largely preoccupied with personal status, control over resources (primarily land) and the development of contractual relations (mercantile capitalism). Industrial capitalism transformed the entire social structure, engendering urbanisation which enormously increased the frequency of interaction among strangers. Important, because unlike acquaintances or intimates, strangers would have less incentive to exercise care not to injure one another inadvertently and would find it more difficult to resolve the differences when injury occurred. At the same time interaction between friends and intimates became progressively limited, ultimately confined to the nuclear family. Intimates commit most intentional torts. But within the nuclear family they are rarely resolved by the legal system, (a) because they would destroy the relationship and (b) the persons committing torts are sufficiently powerful.

Industrialisation gave capitalists the power to effect extensive damages, first through domination of unprecedented amount of physical force (factories, railways, etc) and now through toxic chemicals. Concentration of capital and mass production increased the number of workers, consumers and others who might be banned by capitalists' indifference or miscalculation.

Capitalism also shapes the experience of injury. It simultaneously destroys the obligation of mutual support outside the nuclear family and pays those within it who are gainfully employed at a level of wages too low to support nonproduction members. As inability to work becomes tantamount to destitution or dependence upon charity, the core of damages is compensation for loss of earning capacity. Second, capitalists, middle classes and even industrial workers acquire consumer goods which require protection against inadvertent destruction. Third, family is no longer able to care for injury or illness, partly as members must seek employment outside and partly because care itself is commodified and monopolised by the emergent medical profession. As the monopoly allows professionals to command high fees, injuries 'cost' a great deal more. Finally, commodity form is progressively extended to non-productive experience.

Capitalist tort law exploits and alienates the victims in ways parallel to exploitation and alienation of labour. In pre-capitalist society, injury, like work, creates use value; it elicits cure from intimates who are motivated by concern and promotes demand for apology backed by threat of retribution. The capitalist state which asserts its monopoly of force to obstruct the latter response, also creates a market for injuries in torts and legal system. It separates, through the legal profession, tort victims from means of redressing their wrongs and medical profession; disabled victims and intimates from caring for the ill. In each instance, a faction of the ruling class mobilises the power of the state in its own interests to protect the monopoly of expertise of lawyers and physicians. The lawyer then combines legal expertise with the victim's injury (as the capitalist combines capital with the workers' labour) to produce a tort (a commodity) that has exchange value both in the state created market

(the court) and in the dependent markets (negotiated settlements).

As capitalists have to maximise profit in a competitive market, they must sacrifice health and safety of others. Another reason why capitalism fosters injury is that it must expand its market and increase consumption; torts contribute to it just like planned obsolescence and warfare. Tort law, following legal liberalism, eliminated formal legal discrimination. So, with its development discrimination between patients who are victims of charitable hospitals and those of non-charitable hospitals, etc. were eliminated. But it could not and cannot remove certain deeper inequalities.

First, of course, the inequality in the incidence of injury and illness: capitalists and professionals are subjected to totally different hazards than those suffered by workers at the work place or women at home. The rich can avail of the best medical facilities, equipment and medicines, not so the poor. Secondly, the class and gender will affect the extent to which and the way in which the experience of injury is transformed into a claim for legal redress, the sense of entitlement to physical, mental and emotional well being (women only recently began to legally resist abuse by their husbands, workers are only now coming to view hazards at work place as a negotiable demand), the feeling of competence to assess a claim, the capacity to mobilise legal process, ability to overcome delay, etc. Third, the law also discriminates in the availability and generosity of the remedies it offers, the biggest difference being between tort damages and other compensation systems. An industrial worker is far more likely to be injured at work than a person from another occupational category, such injuries are relegated to workmen's compensation, which pays only a fraction of tort damages and rejects altogether certain tort categories. Other oppressed categories, women, children, dalits, religious minorities, are also excluded from tort recovery. They are most frequently the victims of violent crimes and other social crimes whose assailants are either unidentifiable, unavailable, financially irresponsible or simply too powerful. Women and children injured by relatives are left without any remedy. Another type of discrimination is internal to the tort system. Pecuniary damages are paid on the basis of income of the person. Even the damages for pain and suffering are often expressed as multiples of pecuniary damages. So a poor person will get much less damages than a rich person. Women will get much less than men.

Production of Illness: Capitalist tort law systematically encourages un-safety. The dynamic of capitalism, the pursuit of profit impels the enterprise to endanger the workers, its employees and those who inhabit the environment it pollutes. As the cost of safety reduces profits, a capitalist must be as unsafe as he can get away with being. Apparently the Tort law curbs these destructive tendencies through the threats of damages. But this is not what actually happens. First, compensation is paid on the basis of the status of the victim not of the offender, the doctor for instance. Second, the insurance mechanism goes a long way in virtually nullifying the burden on the offender. Third, as seen above, due to the discriminatory aspect of Tort law many injuries and victims are excluded from its purview.

In fact Tort law motivates the entrepreneurs and the professionals to seek to evade the consequences of carelessness not to enhance safety. Their response to the threat to tort liability is to strive to externalise accident costs by concealing information. For instance, the market deterrence, by mandating the payment of money damages, subverts collective efforts to exert control over safety, damages are paid only for an injury caused by the offender's act. This means that unsafe conduct causing no injury is not deterred and that the legal attention is focussed on the temporarily delineated act of an individual rather than on the ongoing activity of a collectivity. Capitalist Tort law, like capitalist medicine, is obsessed with individual care at the expense of collective prevention because capitalism creates a market only for the former. Thus, despite the unease exhibited by doctors to the term trader or entrepreneur applied to them, the tort ultimately treats them as skilled traders and in the course of time, on the other hand, the medical profession loses interest in curing patients and only concentrates on treating as many as possible. Also the costs of damages are externalised by increased professional fees and insurance.

Health care systems and malpractice litigation:

In previous chapters we discussed that all market economies of the developed countries do not have identical health care systems. While in the UK and Canada the state has adopted direct interventionist role with an intention to make health care universally accessible to people, in the USA the state intervention is founded in the liberal ethos of the least direct intervention with social security measures for providing health care to the aged and the indigent. These three countries have not adoped any direct systematic measure to regulate the malpractice litigation or have not adopted any universal method for compensating the victims of malpractice. They have left this task to the courts. And one finds that the malpractice litigation in these three countries have evolved differently.

In these three countries, the malpractice litigation has considerably increased, particularly from the 1960s. The malpractice claims in the UK and Canada are considerably low as compared to the USA. The number of claims filed per physician is about eight times higher in the US than in Canada. Between 1976 and 1987, 33 percent of the Canadian claims resulted in payments as compared with between 43 and 50 percent of the US claims (Coyte, Dewees, Trebilcock, 1991:89). The malpractice litigation in the UK are also not as high as they are in the USA. The expert feel that while in the USA there is a crisis like situation due to the sharp increase in litigation, in the UK there is no such acute crisis, though the adverse effect of any sharp increase in litigation on National Health Services would be more damaging. In fact, although the UK and the USA share a common legal tradition, the difference in the access of claimants to the courts and the British judges have defended a conservative approach to claims against doctors by citing the need to discourage American style malpractice cases in Britain (Quam, Penn, Dingwall, 1987).

However, despite high use of malpractice suits for regulating medical practice and for

compensations, the actual direct benefit to people who have suffered due to negligence is not so great. For that matter, the regulatory benefit of making providers accountable is also very low. For instance, in a large study (Harward medical practice study 1) of 30,121 randomly selected records from 51 randomly selected acute care non-psychiatric hospitals in New York state in 1984, it was found that the adverse events due to medical intervention occurred in 3.7 percent of the hospitalisation and 27.4 percent of the adverse events were due to negligence. (Brennan et el, 1991: 370). In the Harvard medical practice study III, it was found that 98 percent of all adverse events due to negligence in the study did not result malpractice claims. Further, the number of patients in New York State who have serious disabling injuries each year as a result of clearly negligible medical care but who do not file claims (5400) exceeds the number of patients making malpractice claims (3570). And only half of the claimants would eventually receive compensation (Localio et. el, 1991).

While these studies show that many hospitalised patients receive injuries due to negligence, there is not sufficient research done to explain why so few of the injured patients actually file claims. And interestingly, this is the situation in the country where the malpractice claims are supposed to be the most rampant. The authors of the study also feel that the results of their study raise questions about whether malpractice litigation promotes high quality in medical care. Further, they found the rate of claims a poor indicator of the quality of care. They concluded that "the civil-justice system only infrequently compensates injured patients and rarely identifies and holds health care providers accountable for substandard medical care".

Thus, the conclusions are inescapable. The medical malpractice litigation, in the absence of other consciously driven reforms, may in the initial stage lead to some reorganisation, such as introduction of better method of recording informed consent, preparation and preservation of medical records etc, but these in themselves would not be sufficient in highly improving the quality of care. In fact, the high level of litigation in the US, as compared to say Canada, does not seem to prove that the quality of US health care system is proportionately higher. Nor that all those who suffer injuries are compensated, for only a small proportion of them actually litigate and of those who litigate, a maximum of half get actual compensation. In effect, the very purpose of the tort litigation to compensate for the loss, gets greatly lost. Instead, very few symbolically get very high compensation while the rest live with injuries without any compensation.

Any reform in the compensation system to ensure that all those who get injured actually get some compensation would demand corresponding reform in the structure of health services. It is difficult to have a health care system which works on the logic of the neo-liberal market economy but the compensation system is not determined by the similar market laws. More so in the case of the USA whose health care service is often described as the one devoid of real system (Morgan Capron, 1989: 503). For essentially, the health care there is like any consumer item sold by various types of multiple providers on the market and the state plays little role in integrating such provision in a genuine system. In England and Canada, on the other hand, there is a

comprehensive universal provision system in place, and so there have been periodic debates there on replacing the litigation system with the no-fault compensation.

The tort system has been criticised for being unpredictable, expensive and unfair. As early as in 1978, the Pearson Commission on Civil Liability and Compensation for Personal Injury, in its report responded to the need for reform in the tort system in the UK. Though the report did not recommend wholesale abolition of the tort system, it made a number of specific suggestions for reforming the tort system. It also did not recommend no-fault scheme for all medical injuries. However, in certain aspects, such as, injuries due to vaccine, medical research, defective drugs, severely handicapped children etc, it suggested strict liability on the providers/manufacturers and allowances. The Commission's proposals were not fully implemented in England. But the very fact that a Royal Commission looked into the issue and all subsequent debates have concentrated on its suggestions and tried to judge whether the time was ripe for no-fault compensation shows that in the expensive and unfair tort system has a potential to create problems for the commitment to universal access to health care. And that, such systems are better breeding grounds for rational reforms in the tort system than the market driven US health care services.

The no-fault scheme, however, operates in few countries, notable of them being New Zealand and Sweden. There are doubts about such scheme being less expensive. For there may be more expenditure in order to compensate most of the victims as compared to the tort system which compensates only few victims. Nevertheless, the important part is that in the tort system, a big chunk of the expenditure made is on fighting the litigation, only a part of the total expenditure actually going to the victim. In the no-fault scheme, as it is operational in New Zealand, over 90 percent of the expenditure goes to the victims in compensating for injuries as the expenditure on courts, lawyers etc is greatly saved.

Lastly, the malpractice litigation have direct relationship with the increase in defensive madicine and increase in the cost of care. While the already prevalent high level of irrational therapeutics and cost are intolerable in the country like ours, the increase in the defensive medicine would only compound the problems.

Thus, when one deals with the issue of framing a legislation for the universal access to minimum and quality health care, one should also combine the new legislation with the substantial reform or replacement of the medical litigation system.

9. CONCLUSIONS

A conclusion, asserted by us very often in this report needs to be restated:

The health legislation are very few as compared to the size and problems in the health care sector. The need for having a comprehensive health care act, framed in order to gear the entire health sector to the objectives laid down in the policy documents, is as glaring as it was half a century back. We feel that such a comprehensive legislation is required for restricting the inexorable march of health care services in the same direction that the US health care services have taken. It is also required in order to make all players and providers in the health care to develop in the same direction delineated in the health policy and operationalised by the legislation.

The historical experience of the advanced countries show that none of could make any progress towards the universal access or near universal access to health care services without bringing the public and private sectors under the purview of a single policy operationalised through a common or near common legislation. The social objective of the universal access to health has never been achieved within the market economy and democratic political structure unless the state has intervened massively in order to streamline the system of health care delivery. The strategies employed by, say the system in UK and Canada are different, but both of them have a common thing in having aligned their social objective to the policies and legislation. Of course, such systems are also under increasing strain, but all reforms have begun or would begin in these countries from the historical backdrop of the universal access system, would be judged from the same standards and would need to create a strong political support for the change. Further, historically the advanced countries which shied away from such state intervention, policies and legislation, as is the case of USA, have miserably failed, despite have available the technology, skill and finances, in making health care universally accessible to all people. In brief, the slogan of health for all, or in narrower sense, the health care for all, would remain an elusive goal unless it is backed by a policy and legislation to restructure health care in totality for making it universally accessible.

Interestingly, our review shows that although in the last analysis it is the political commitment which make the health policies operational, the support role for formalising the operationalisation by the health legislation is of great importance. Of all things, the health legislation make it difficult for affecting sudden change in the policy. It would need more public debate and mobilisation of political opinion for such change. And above all, it would bring more accountability in the implementation of policies. Thus, the declaration of intent in the policy need to follow by the operationalising law in order to bring out the seriousness of intention. The commitment to health care for all must be seen from this angle at the policy formulation level.

In the present level of development of health care in our country, the non-access to the basic minimum of primary health care to all is not simply a policy issue but also an ethical one. There is a need to legislate, as a justiciable right, the right to basic minimum primary health care for all.

As stated earlier, the need to bring under common frame of regulation the public and private sectors in health care is very glaring. Our review of the health legislation show that the laws are differentially applied to both the sectors. Except the laws related to the registration and training of health care professionals, the rest are not applied uniformly and for that there is no justification. While the government sector is required to implement policies, good or bad, the private sector has not obligation. While the hospital registration laws (not enacted everywhere) are applied only to the private sector, the government sector hospitals are excluded. There is no justification that the minimum scientific standard required for hospitals should be different for the hospitals in public and private sectors.

Further, the existing laws deal at length on the machinery for operationalising the law, the substantial part of the law creating standards for their implementation and right to redressal for people are hardly formulated in the law. When the law lacks standardisation, it is expected the standards will be laid down in the rules of the act. But in most of the health laws, the rules also overlook this task. As a result, we have created laws but not created uniform framework for their proper implementation. For instance, the hospital acts talk of the adequate physical standards and proper qualification of health care staff, but fail to detail anywhere the standards of adequacy and the properness. Similarly, the code of ethics in the medical council act talks ethical duty of doctors to keep their knowledge and skills updated, but the laws fail to provide any standard for updating knowledge and fail to link it with the periodic renewal of registration.

Thus, just like many policies which have shown tardy implementation, most of the health laws operationalising policies have shown tardy implementation.

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The Indian Medical Degrees Act, 1916
The Indian Medicine Central Council Act, 1970
Dentists Act, 1948.
Indian Nursing Council Act
The Indian Homeopathic and Biochemics Act.
The Maharashtra Medical Council Act, 1965.
Maharashtra Medical Council Rules, 1967.
The Indian Medical Degrees (Maharashtra Extension and Provision for Uniformity) Act,1961.
Maharashtra Medical Practitioners Act, 1961
Maharashtra Council of Indian Medicine Rules, 1961
Maharashtra Medical Practitioners (Registration) Rules, 1961
The Maharashtra Board and Faculty of*Ayurvedic* and *Unani* System of Medicines (Executive Committees) Rules, 1962.
The Maharashtra Medical Practitioners (Publication of Medical List) Rules, 1966
Maharashtra Council of Indian Medicine (Election) Rules, 1967
Maharashtra Board and Faculty of *Ayurvedic* and *Unani* Systems of Medicine (Conditions of Service of Registrar and Staff) Rules, 1968
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Consumer Protection Act, 1986.

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The Coroners Act, 1871.
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The Epidemic Diseases Act, 1897.
The Bombay Medical Act, 1912.
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The Bengal Medical Act, 1914.
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The report of the Select Committee on The Madras Nurses and Midwives Bill, 1924.
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