III
Medical Ethics and Negligence

Medical Ethics and Patients

S S Tinaikar

Some years ago the Consumer Protection Council of Maharashtra, in a case placed before it by a patient alleging a surgeon's negligence, decreed that the surgeon should pay a substantial sum as compensation to the patient. The unequivocal and highly punitive award by a special tribunal being the first of its kind in the country, stirred the entire medical profession most of whose members reacted adversely to what they felt was an intrusion by a body which was not equipped nor competent to judge the performance of a practising physician or surgeon. The normal civil or criminal laws of the land and the courts which administer them, and better still the state Medical Councils, consisting almost exclusively of either practising doctors or of those who are medically qualified to practice, is universally accepted by the entire medical fraternity as the only judicial forums which can pass judgments on the ethical, moral or legal conduct of doctors.

It is necessary to understand the historical perspective in which the medical profession has evolved, and more recently, the international and national code of conduct and ethics that has been laid down, for defining the doctor patient relationship. This relationship is different from all other human relationships where a professional service is required to be rendered by one human being to another. Through all the exhortations, pledges, code of conduct that a person entering the medical profession is enjoined to adopt, a few exceptional words indicating the spirit of this service, have been repeatedly used which are not found in any other service. Apart from the ancient Oath of Hippocrates, which enjoins the doctor to "keep pure and holy both my life and art" and "abstain from intentional wrong doing and harm, especially from abusing the bodies of man and woman", every prescription of conduct of doctors stressed the 'sanctity', 'holiness', 'sacredness' of another human body which is entrusted to a doctor for cure or alleviation of suffering, and which raises their mutual relationship beyond a normal contractual relation-

ship of a commercial nature, even though a fee may be charged for the service rendered. The Declaration of Geneva, adopted by the World Medical Association in September 1948, enjoins a person at the time of being admitted as member of the medical profession to "solemnly pledge myself to consecrate my life to the service of humanity", and appeals to his 'conscience', 'dignity', 'honour' and 'noble traditions of medical profession' and to have "utmost respect for human life from the time of conception". ... and that "even under threat, I will not use my medical knowledge contrary to the laws of humanity", "it is unethical to use methods of treatment whose value is not recognised by medical profession", "A doctor owes to his patient complete loyalty and all the resources of his science". Later the Declaration of Helsinki, made in June 1964, raises the profession to still higher levels, "knowledge and conscience must be dedicated to the fulfilment of the mission to safeguard the health of the people". Note the word 'mission'.

Closer home, by a special statute, the Indian Medical Council Act, 1956, regulates the Council which is a representative body of the medical profession for controlling the standard of medical education and conduct of medical practitioners. The code of medical ethics laid down for observance by all the doctors starts with a fundamental principle, "The prime object of the medical profession is to render service to humanity, reward or financial gain is a subordinate consideration"... "The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care rendering to each a full measure of service and devotion". In order to maintain the purity of medical profession by eliminating undesirable immoral and corrupt elements, the code exhorts those who are within it, "A physician should expose, without fear or favour incompetent, corrupt, dishonest or unethical conduct on the part of members of the profession".

The practice of medicine, however, is not expected to be purely charitable activity, but a profession, where a service is expected to be rendered for a fee, and hence further restrictions are imposed by the Code of Medical Ethics on the manner in

which fee can be levied and also on the amount. "The ethical physician engaged in the practice of medicine limits the sources of his income received from professional activities to services rendered to the patient. Remuneration received from such services should be in the form and amount specifically announced to the patient at the time service is rendered". "Only reasonable remuneration should be charged for any professional service rendered". Fellows of the Royal College of Physicians of London are debarred from suing for fees from defaulting patients. Further, as soon as a registered medical practitioner agrees to treat a patient, a doctor-patient relationship is legally established, and it is obligatory on him/her, as per duties specifically laid down by the Indian Medical Council under the act, to obey a summons for attendance from a private patient as long as such a relationship exists.

The accountability of doctors, particularly, those who treat patients for a fee and their obligations must be viewed in this background. Specific enunciation of what doctors should not do, in the Code of Ethics, is an indirect revelation of what some are prone to do and is a forewarning to them that their registration as a medical practitioner by the Medical Council is conditional on fulfilling the ethical standards specifically laid down, apart from general moral principles which control all human relationships and which are the subject of normal civil and criminal law. The Medical Council, however, is primarily not a punitive body, even though it is vested the powers of a civil court when it conducts an enquiry against the allegation of misconduct against a doctor who has allegedly violated the code of ethics, but its punitive power is restricted, even in a case of proven crime or misconduct to reprimand, or to suspend or remove the registration of a medical practitioner from its register, which means that s/he cannot practice as a doctor. No remedy by way of any relief, financial or otherwise, is available to victims or their relations.

Further, the Council which is mainly an elected body, elected by the medical fraternity from its own community, cannot be expected to exercise an unbiased, objective and firm judgment against its constituent, which an independent judicial authority

would normally exercise. The authority of the the Medical Council, even in regard to controlling and giving recognition to medical courses, educational institutes is hardly respected. Medical colleges, with inadequacies of infrastructure and, facilities have been opened by many private trusts, with the support of local universities and state governments, in many parts of the country, in total disregard of Medical Council of India. The state level Medical Council, constituted by an independent act of the state legislature and which enjoys certain authority over the conduct of medical practitioners registered with them, is looked upon more as a body or council of the doctors and for the doctors. No relief is expected to be given to a patient. It is but natural that when this self protective cocoon, in which the medical practitioners functioned is now torn by the intrusion of a body for whom the interests of the patients as recipients of doctors services are uppermost viz, the Consumer Protection Council, that the doctors should try to warn of the adverse consequences of its allowing it to question their misconduct.

Hospitals, nursing homes, are as much responsible for observing medical ethics as the doctors examining and treating the patients either in the consulting rooms or by visits to the patient's residence. But strangely enough, the control by a public authority on the management, of the nursing hospital and on the standard of treatment of patients from medical, hygienic and ethical points of view is practically non-existent. Many big hospitals registered as trusts, and enjoying a number of concessions in the import of medical equipment, under the Factories Act and Income Tax Act, function in total disregard of medical ethics or concern for the patients. Indeed, emboldened by patronage of those who have money power or social contacts, the management of these so-called charitable hospitals thrive on all kinds of undesirable practices which some unscrupulous medical practitioners on their establishment may indulge in. Installation of high tech and costly medical equipment for diagnostic purposes, result in the patients being referred in large numbers for these diagnostic analysis to make the investment repayable. Thus, four lithotripters in Bombay within a radius of about 15 km, five magnetic resonance imaging centres within 10 km, each one costing crores of rupees involving scarce foreign

exchange and customs duty concessions, adorn some of the big hospitals, only for competing with one another.

As these hospitals financially depend on their doctors who are free to practice outside the hospital and multiply their earnings, the interest of the doctors, so far as earnings of the hospital are concerned, get identified with the services, fees and practices of the doctors. Some of the worst practices indulged in by some consultants, either with the permission or connivance of the management which derives financial benefit from them, are the liberty given to a doctor to charge fees in addition to those which are prescribed by the schedule of fees of the hospital, to directly collect an undisclosed amount from the patients, to charge excessive visit fees or under the pretence of night visits when such visits are not required at all, to refer a patient unnecessarily to other specialists or for various tests all of which, like a taxi meter, go on escalating the charges with automatic precision whether you are aware of it or not!

Hospitals registered as public charitable trusts have, under the act under which they are registered, patients as beneficiaries of trust funds, and the management of the trust generally and the trustees in particular are under the law accountable to the patients. In the strictest sense all those associated with the patient care in such hospitals are in public service to the patients no less than those who serve in government or municipal hospitals. Not only that, but they attract greater liability and must conform to much higher discipline and medical ethics as the patients are paying very high fees and charges for medical treatment. One would therefore, expect the management to set up a system in the form of committees to objectively and impartially attend to the grievances of the patients, whether regarding serious allegations of overcharging, unnecessary medication or negligence in treatment, etc. A committee for evaluating the performance of different specialists/consultants within a speciality; an ethical committee to carefully monitor that any research carried out on material collected from the body of the patient is strictly in conformity with rules and procedure laid down for the purpose, and is with the full knowledge and consent of the patient, and a drugs committee to lay down

standards of administration of drugs and keep a record of therapeutic value, and so on. 'Death' conferences, post-mortem study of cases where the cause of death could not be exactly identified ought to be a normal part of a medical hospital devoted to medical excellence in patient care. Deaths during the operations, when the patients are under anaesthesia, are looked upon with great suspicion and the surgeon or anaesthetist is expected to report such deaths at once to the police for holding a public enquiry, as such a sudden death is of considerable medicolegal importance; sometimes it could be due to inexperience and defective judgment of an anaesthetist, giving or repeating of drugs like morphia, atropine before anesthesia at wrong time, vagal inhibition while putting an intratracheal tube, obstruction of airway or spasm resulting in asphyxia, hypotension as a result of spinal anaesthesia, etc. However, in practice, it is circumvented by doctors, by not pronouncing the death on the operation table but concealing or suppressing it by temporarily reviving the patient and by putting him on the ventilator, which gives the impression of breathing, till the patient is taken to the ICU, after which his death is disclosed. A recent case reported widely in one of the most prestigious and costliest hospitals of Bombay, should not be treated as exceptional, as only a thorough probe by the patient's relatives and informal disclosures by those who are present in the operation theatre can give a faint idea of what happens within the operation theatre. And this is almost impossible to prove in a criminal court, which normally depends on independent material evidence, other than those of witnesses. The nursing homes which provide only facilities to doctors to operate and may not have employed the surgeons and the anaesthetists who might be responsible for deaths during anaesthesia are responsible for strict observance by the doctors who use those facilities, of code of ethics and fulfilment of duties cast on the doctors.

We have a long way to go in this country before we find in the medical profession a very high sense of responsibility and patient care. But so long as life is cheap, litigation undependable for quick relief, and above all, lack of awareness of the rights of a patient make him totally dependent on a doctor's say, we may not expect a substantial improvement.

Medical Ethics as Doctors' Legal Obligation

Amar Jesani

Earlier the terms 'ethics' and 'morals' were used interchangeably. In popular parlance, to have certain morals in medical practice does not automatically confer 'rights' to the patient. However, medical ethics is not merely a moral code but a legally sanctioned code of conduct acceptable and normal within the medical profession. This does not mean that morality or moral theories do not influence medical ethics, but that medical ethics must be understood, analysed and practised from a rational standpoint as prevalent within the profession at a given point of time. This rational component of professional conduct is legally codified under the code of medical ethics of the legally constituted Medical Council with which all qualified medical practitioners must be registered.

The registration as well as the conduct as per code of ethics is essential because, "Doctors use technical skills and expertise which the untrained person does not possess. Possessing these skills gives him great power over his patients who by the very fact of being patients are dependent, ill and vulnerable. In caring for his patients, a doctor makes a series of judgements and decisions which patients have the right to expect are made fairly in the light of the doctor's knowledge and experience." (British Medical Association). Thus, although the code of medical ethics is for an internal self regulation of the profession it is an order to fulfil certain rights and expectations of the patient. In a nutshell, the code describes a doctor's duties towards the patient and the doctor's duties are, therefore, the rights of the patients. If these rights are not fulfilled or duties not performed, then the doctor in question losses his or her right to be part of the profession.

At the macro level, the professionalisation of medicine has meant conferring a monopoly to practice medicine to those who are properly qualified and registered under the law. It is a specific kind of trade off between the profession and the society, wherein the society has granted some monopoly to the profession to practice

medicine *in lieu* of the profession's commitment to society, that it will strictly regulate the conduct of doctors amongst themselves as well as in relation to the members of the society. Therefore, society has a right to demand that the profession strictly implements the agreed code of ethics in all aspects. It follows from this that in so far as the profession continues to regulate the conduct of its members, society does not interfere with the *autonomy* of the profession. But when it fails in its commitment to properly implement the code and in disciplining these members who violated the code, society steps in with separate laws which necessarily restrict the autonomy of the profession. This phenomenon was clearly visible before the law against sex determination was enacted in Maharashtra. Concerned activists had appealed and some had even filed a complaint on this issue before the Maharashtra Medical Council. But the latter, not only failed to take action, some of its leading members tried to completely exonerate the profession from its social responsibility on this issue. As a consequence, the state enacted a separate law which necessarily curbed the authority and the autonomy of the profession. This process is now being repeated at the national level as the Medical Council of India does not seem to be ready to inculcate necessary social responsibility in the profession.

There are four universally accepted and major principles on which medical ethics are based. Of course, there are many interpretations, differing emphasis and addition or substraction of these principles. (1) *Principle of non-maleficence*: first of all, do no harm. (2) *Principle of beneficence*: Not only that harm is not done, but the medical intervention ought to be to prevent and remove harm, and thus, should provide health benefits to the patient. (3) *Principle of autonomy*: The principle of autonomy is universally accepted but that of 'medical paternalism' so highly prevalent in medical practice in India, is not. The autonomy of the patient must be respected at all times. (4) *Principle of justice*: Outlines the social responsibility of doctors.

Medical Councils

In the 19th century, medicine along with the university teaching, law and the ministry, underwent professionalisation. The medical profession succeeded, after prolonged agitation, in

getting recognition for their status and prestige in 1858 when an act creating the General Medical Council (GMC) was passed in the UK. Initially, the medical councils of developed countries paid almost exclusive attention to reducing competition from outside and within. Thus, the traditional practitioners and quacks were forcibly eliminated from the market and so from competition in the later part of the 19th century. Elaborate codes were made to restrict or eliminate unhealthy competition within the profession that was lowering the status and prestige of the profession. At the same time entry to the profession was restricted by getting control over the medical education and the registration of doctors. To these was gradually added the internal regulation or disciplinary procedures to curb misuse of power detrimental to patients' well being.

In India, the process began in 1912 when the Bombay Medical Act was passed. This was followed, in 1914, by Madras Medical Registration Act, Bengal Medical Act and so on. It was only in 1933, the Indian Medical Council Act brought the higher education in medicine under the purview of a national level medical council. After independence, separate national level and state level councils were created for allopathy, homeopathy and the Indian Systems of Medicine. The national level councils have control and supervises medical education whereas the state councils maintain registers of doctors and have powers to discipline doctors whose conduct were found to be unethical.

The state level medical councils (we will use the Maharashtra Medical Council, MMC, for illustration) have all but one member who are doctors. The MMC has 23 members, of which nine (about two-fifth) are directly elected by registered doctors through postal ballots. This system of direct elections makes it very expensive for contesting candidates. In order to reach out to more than 50,000 registered doctors in Maharashtra, say twice by post during the elections, the candidate has to spend lakhs of rupees. This makes it difficult for low earning ethical doctors to contest. In addition seven members (two of them *ex officio*) are government nominees (one of them a non-doctor). Thus, about one-third of the members are appointed by the state government. Of the rest, one is nominated by the College of

Physicians and Surgeons and others are elected by the medical staff of the medical colleges of each university.

Under Section 22 of the MMC Act, the Medical Council is empowered to hold inquiry, *suo moto* (on its own) or on any complaint made to it, against any registered doctor or doctors. This is properly codified in the Chapter VI, rules No 62 to 75 of the Rules of the MMC Act. Thus, the Medical Council can act against the erring doctor even if no complaint is filed by the patient(s). Further the Council has the same powers as are vested in civil courts under the Code of Civil Procedure, 1908. This makes all inquiries on the misconduct of doctors, to be judicial proceedings within the meaning of sections 193, 219 and 228 of the Indian Penal Code. The Council also has powers to punish doctors who are found guilty of any misconduct in the properly held inquiry. Accordingly the Council can warn a doctor, or can temporarily or permanently remove the name of the doctor from the register. But the Council has no power to award compensation to the patient or the complainant.

From the above information, the following patient points must be kept in mind:

(1) When there are persistent reports of unethical practices in the profession (eg organ trade, cut practices), the Council cannot advance a pretext that there is no specific complaint field. The Council has *suo moto* power to investigate such situations and after proper inquiry, punish those who are guilty of misconduct. This also provides scope to the patients' organisations and social organisations in filing complaints and in pressuring the councils to play more active role. The situation is similar to the high courts' and the Supreme Court's 'activist' role in the public interest litigation. Unfortunately, not much has been done to use this provision for the benefit of patients and to cleanse the profession of bad practices.

(2) While conducting inquiry into the complaint against doctor(s), the Council is deemed to be a civil court. The business *other than the inquiry* is considered under the act confidential. But its function as a court during the inquiry makes the inquiry

an open one, as is found in any court. The Council has, unjustifiedly, kept the inquiry a secret and has not allowed people to observe the proceedings (as is done in the court). This practice of the Council can be easily challenged in the high court by the interested complainants and the proper norms of open 'court' inquiry re-established.

(3) During the inquiry, all members of the Council (in Maharashtra) act as judges. Since most of the inquiry need several sittings of the Council, there is a turn over of members on the dates of hearing. Thus, it could happen that a majority members, who were not consistently present during the inquiry, get the authority to draft the final judgement. Although the act is silent on this point (except that the final judgement should be voted or passed in the council meeting), there is nothing in it to prevent the Council from drafting its own bye laws to make its disciplinary proceedings more stringent and efficient.

(4) There is an obvious lacuna in the rules of the act. The inquiry is held in two stages. The first stage is for ascertaining the *prima facie* case. This is done by the president and the executive committee. At this stage, the complainant is not allowed to be represented by a lawyer during the hearing, if organised by the president at all. Only if at this stage the patient or complainant is able to convince the president and executive committee, the actual inquiry takes place. In that second stage, the complainant is allowed to be represented by a lawyer.

(5) There is no consistent relationship between the gravity of misconduct and the punishment given. The latter is also a rare event. There is a need to formulate some norms for the punishment.

(6) In so far as the disciplinary functions of the Medical Council are concerned, they are highly underdeveloped as they are least tested by the complainants and the little is known about the real effect or implementation of the punishment of the accused. Thus, unless complaints are filed and relentlessly pursued to their logical end, one would not definitely known the scope of patient redressal under the act.

Code of Ethics

Now let us turn our attention to the code of ethics which embodies many rights for the patient. The Medical Council's code of ethics is, in fact, framed as 'duties of doctor' in relation to various situations and persons. The Medical Council of India's Code of Medical Ethics has seven major sections and under each section, the specific principles are enumerated. These sections are followed by a section which provides general guidelines on the disciplinary action and a concise list of misconduct which obviously is not exhaustive. Areas covered are: (a) General principles (it has nine principles enumerated), (b) Duties to patients (four principles), (c) Duties to the profession (four principles), (d) Duties to each other, or doctor-doctor relationship (two principles), (e) Duties in consultation (eight principles), (f) Duties in cases of interference (three principles), (g) Duties to the Public (three principles).

All in all, these seven sections and 33 principles provide *directives* on the four aspects of doctor's professional work and personal life, namely, (1) doctor-patient relationship, (2) doctor-doctor relationship, (3) social responsibility and public health, and (4) Personal integrity and purity of character. It should also be noted that the present code of ethics was approved by the Government of India under the Indian Medical Council Act on October 25, 1970, and that, in keeping with the current trends in the medical care, it has second largest section on the duties in consultation. The code of ethics is given in full elsewhere in the book so we will not discuss is provisions in detail. The interested readers are requested to go through it. We will only make some general points which are useful for the patients' rights. The more specific rights for patients can be deducted by individuals concerned in light of the general points made. First of all, there is no water tight compartment between any two sections of the code. They all are related in various ways and in all of them the primary focus is to safeguard individual patients and people's interests.

Second, it follows that the parient has certain rights under each section. This should be specified because it is often mistakenly believed that the patients' rights are codified only in the first two sections and those of the society at large in the last section. For instance, if there is a real perversion of doctor-doctor relationship, it is also the patient's and society's concern. The Medical Council and the doctors involved in such perverted relationship are accountable to the individual patient who has suffered due to that and to the society in general.

Third, the patient can approach the Medical Council with a complaint on violation of most of the principles in the code. The list of misconduct given at the end is not exhaustive and does not prevent the patient from making complaint on misconduct related to the principles. As it is in any court, one is of course required to show that the same has produced bad effect. Fourth, since the Medical Council has the authority to take *suo moto* action, in order to active that mechanism one can always test out activism of the Council by filing public interest type of complaints. Fifth, there is a scope to demand institution of Medical Council inquiry into the persistent reports of unethical practices like fee sharing, organ trade, doctors' participation in human rights violation, etc.

In addition, as stated earlier, there is a need to make the Medical Council inquiry into misconduct an open proceeding. That perhaps may start exerting lots of public pressure on the Council to hold such inquiries in more organised and methodical way and it is forced to give explanation for the quantum of punishment given.

Lastly, I feel that there are certain lacunae in the act, the more important of them being: (1) Need to grant more powers to the Council, including the creation of an independent investigation mechanism; (2) To provide more funds for the Council; (3) A need to make members give more time to Council work; and (4) The need to create some mechanism to have regular sittings of a small disciplinary committee of the council in the various regions of the state. However, while arguing and agitating for such amendments in the act, I feel that equal priority should also be given to use and exhaust the existing provisions under the act.

Role of Medical Councils
Protecting Doctors?

Colin Gonsalves

The Maharashtra Medical Council set up under the provisions of the Maharashtra Medical Council Act protects the interests of erring doctors and hardly ever performs its duties according to law. It is only recently that social activists and lawyers have vociferously taken up the issue of medical negligence and that is why a few cases have been reported in the newspapers. The situation regarding medical negligence, however, is one of generalised misery and very few of the potential cases are ever filed and of the cases filed, very few are proceeded with.

Secrecy

Attempts by journalists, lawyers or progressive groups of doctors to determine how many cases have been filed and the progress made in each case have been frustrated by the Council. The Council's proceedings are conducted in a shroud of secrecy that is not only unwarranted but also illegal. The registrar has even refused to reveal the number of cases filed every year and the backlog prevailing; the person would be told that such information cannot be disclosed. This is why Saroj Iyer, a journalist of the *Times of India* who was rebuffed in this manner, filed a writ petition in the Bombay High Court. Her further request that she ought to be permitted as a journalist of a leading newspaper to attend the proceedings in the case of Singhi v/s P B Desai and others was likewise turned down. She was told that the proceedings of the Council are confidential, and apart from the parties directly concerned and their advocates, no one else is permitted to attend. Persons like her are often told that since the trial involves grave charges against leading doctors, their prestige would be lowered in the eyes of the public if the proceedings are reported. After all, the argument goes, the doctor is innocent unless proved guilty and reports would inevitably result in defamation and harm the doctor's practice.

This argument is only to be made to be rejected and shows the abysmal depths to which the Council has fallen. All criminal trials are public even though the charges levelled against the accused are of a serious nature and even though the person accused may be prominent. All criminal trials proceed on the assumption that the accused is innocent unless proved guilty. Despite this, and although criminal proceedings are more serious than those of the Council, it is a basic principle of law that all criminal trials be open to the public. Justice must not only be done but must be seen to be done. If in the proceeding before the Council the doctor may be punished by way of a warning or suspension of his licence to practice, the criminal trial can have far more serious consequences. Therefore, if an open trial is part of the criminal justice system, and in fact is a part of the justice system generally, there is no reason why the Council should cloak itself in secrecy.

Even if civil proceedings of a personal nature like matrimonial cases, are always conducted in the open and the public have a right to attend the proceedings. There is no reason why doctors should be placed on a pedestal above ordinary people.

Saroj Iyer was denied the right guaranteed under Article 19(1)(a) of the constitution of India for as a journalist, freedom of speech and expression meant the right to inform the public of the developments before the Council. The Council in reply wrongly relied on a rule which required the resolutions of the various meetings of the Council to be kept confidential. This rule referred to the internal administrative meetings of the Council not to the enquiries for misconduct. This rule has no relevance whatsoever to the enquiries conducted by the Council in respect of the medical malpractice. But the Council has functioned to this day away from the eyes of judicial review and hardly any cases regarding the functioning of the Council have been taken before the high court and so the procedures and practices of the council have carried on in an unsatisfactory manner without any check. By eliminating the press, enormous damage has been done to the public.

One area of great wrongdoing is in the exercise of the power of the Council to throw cases out at the initial stage on the

ground that no prima facie case is disclosed. In this area, the Council functions arbitrarily. The accused doctors are called before the Council and the complainant is also summoned. The accused doctors being highly qualified and academically very proficient argue their own cases efficiently without the assistance of lawyers. In fact they do not need lawyers. The complainant on the other hand is very often an illiterate person and even if literate, seldom has any idea of the medical issue involved. At the stage of determining prima facie whether the charge of infamous conduct is made out, the Council does not permit an advocate to appear on behalf of the complainant. Although there is no rule authorising the Council to do this, it bars lawyers at a very crucial stage of the 'medico legal' proceedings. In most cases the complainant is unable to put forward her case without the assistance of a lawyer while doctors are able to cover up for their misdeeds.

The close connections between the Council members and the accused doctors is another problematic point and although the relations are sometimes personal, the Council members are not known to recluse themselves in any matter. This gives rise to doubts as to the fairness of the entire process. This is exacerbated by the manner in which members function during the trial. The level of informality is so conspicuous that the Council members are often seen talking to the accused doctors during breaks in the trial. This does not mean any hanky panky is going on but it is certainly a very unsatisfactory approach. Often one finds Council members opening and reading newspapers while evidence is being taken or arguments heard. This is not only disheartening but also an insult to the parties appearing before the Council. The Council members during the trial walk in and out of the room at will. They go to the toilet in the middle of the argument or in the middle of the evidence being recorded and this is not done only in isolated cases. If the members have to catch a particular train and need to leave early they walk out of the proceedings in the middle.

There is also no application of mind and no consistency. From day to day as the trial proceeds, the Council members attending the trial fluctuates. At times there may be 12 people in

the morning session, six in the afternoon and a different lot of six the next day and another different lot of six in the next afternoon. As members arrive on different time, copies of the contemporaneous proceedings are not available to them as copies for the members are cyclostyled after the day's proceedings take place and so the members sit across the table without their set of papers before them, often borrowing the president's set to casually glance through them.

The Council being a body of doctors, one expects them to use their medical expertise to guide the complainant at least on medical issues. This is never done. The Council's underlying principle, though this is never stated, is that unless a doctor gives evidence against a doctor, the case will fail. This is the unstated thumb rule. Now no doctor will ever give evidence against a fellow doctor. Knowing this, the Council ought to either use its medical knowledge to fill up the lacunae in the medical evidence presented by the complainant or failing this, ought to at least suo moto summon medical experts to scrutinise and evaluate the cases. The Council does neither. Even cases where applications are made for doctors to be summoned from specific departments of public hospitals, unless the complainant suggests specific names of the doctor he want summoned, the council will not act. Why is it necessary that a particular doctor be named? Would it not be enough for any doctor from a particular department to be summoned? Cannot the Council *suo moto* act to appoint an expert?

Council proceedings are very different from civil litigation. In most medical malpractice cases the complainants are not able to match the economic power and the influence of the doctors. Complainants do not institute cases to vindicate themselves or to take revenge or to make money but rather to ensure that other persons similarly situated do not suffer at the hands of unscrupulous doctors in the same way. There is, therefore, a strong public interest component involved in the litigation before the Council. Given this situation and the fact that doctors never give evidence against a fellow doctor, the Council must actively intervene and use its medical expertise or summon medical experts in order to arrive at the truth. The Council ought not to

be a lifeless, disinterested adjudicator but a passionate seeker of truth.

The functioning of the Council is so shabby, only one example will suffice to show how sad the state of affairs are. The typist cannot type. Often notes of evidence are typed in such poor English, the sentences do not make sense. Corrections and overtyping abound. The dictations to the typist and the latter's ultimate version of what is dictated to him often results in confusion. In trials such as these, where the evidence ought to be meticulous, the functioning of the Council is most disappointing.

Right to Medical Records

Seizure of medical records is another aspect which requires drastic overhaul. All members of the council know or ought to know that seizure of the records is of utmost importance to a case. But for some very strange reason prompt seizure is never done. Repeated request by complainants to the Council that the medical records be immediately seized or else they would be tampered with are not responded to. The tendency of the Council not to respond to communications is very sad. When the reply does come, it is often a desultory one promising that the matter would be enquired into. In case after case it is suspected that the accused doctors manage to tamper with the medical records in the interregnum between the making of the complaint and the council acting on it, a period which can range in years. By the time the Council calls for the records, the case of the complainant is probably irreversibly damaged.

The attitude of the hospitals and the doctors practising there is downright retrogressive. The medical directors of the various hospitals routinely say that the patients and their relatives have no right to obtain copies of their own medical records. In any civilised country the rights of the patients and their relatives to obtain uptodate medical records contemporaneous to the treatment being prescribed and administered is an established right. From the very day the treatment starts, the patient is told about the line of treatment, explained the hazards involved, informed consent is taken and the medical records given

to the patient on a day-to-day basis. Disclosure of all information is the rule. Precisely the opposite is in vogue in India. No records are given to the patient. No information is given to the patient as to the line of treatment and the hazards involved. At best a cursory generalised casual remark is made as to the risks involved. Consent is taken for granted

It is in these circumstances that the right of the patient to obtain copies of the medical records is most important. The medical director of the Jaslok Hospital refused to give a copy of medical record to relatives of a deceased patient, saying that the records were the exclusive property of the hospital and that the relatives have no right to them. When told by the relatives that they only desired to have xerox copies of the medical records, he refused to give that as well. When enquired as to the reasons for the refusal, he gave us the example of a person who had two wives, both of them fighting over the medical records. The answer to this silly objection is that if a person has two wives, surely both can be given xerox copies of the medical records. But the flippant nature of the response was indicative of the shroud of secrecy that overawes medical practice today. Doctors who are supposed to be preservers of life have become dealers in death.

This is not to say that the medical profession as a whole is characterised by doctors exhibiting such qualities. Hundreds and thousands of doctors working in public hospitals and in rural area do selfless services for the poor. But the medical negligence cases that are now being filed are particularly concerned with those big shots with fancy reputations and huge bank balance who manipulate the public hospital system, dominate the private hospitals and have now turned out to be more businessmen than doctors. And if the prominent cases that have been reported in the press are those where the complainant was wealthy, paid huge hospital bills and yet suffered at the hands of doctors and the Council, one can only imagine what the plight of the poor litigants must be.

At the Maharashtra Medical Council, members routinely take a view similar to that taken by the medical directors of the

hospitals. When requested by the complainant to seize and seal records immediately, the Council does not act. In the circumstances it is apprehended that many cases were spoilt as the accused doctors who have access to the original medical records are able to tamper with or fabricate those records so as to clear themselves before the case comes to trial.

The non-judicial manner in which the Council functions is apparent from the nature of the orders passed by the Council. Very important trials raising crucial issues of public interest and conducted over a period of years is disposed off by the Council with a cursory and peremptory order which runs into about two pages. These orders exhibit total lack of reasoning and application of mind. At the end of a case whether one wins or loses, one at least expects that the issues raised are properly dealt with in a decent order. Not only does the council not deal with the issues involved but it gives no reasons apart from cryptic conclusion. Members never disagree or pass dissenting judgements. Never do they apply their minds seriously to the evidence on record. In some cases since the cryptic conclusions were thought to be only the operative part of the order and the request was made for the full judgement, the parties were told that the conclusion was the entire judgement itself. Nothing could be more unsatisfactory.

The Council is a holiday body, in the sense that it sits only on Saturdays and Sundays. This is a very strange practice. The Council is a statutory body governed by the Maharashtra Medical Council Act and the members are elected to do a public and statutory duty. Nowhere in the statute or rules is a provision found that the Council shall sit only on a holiday. But they have conveniently organised their programme so that the enquiries are conducted only on holidays. Not only that it functions about once in three months or four times a year. No wonder the cases before the Council take so long. Adjournments in a case for any reason would result in the case being placed before the Council after about six months if not one year.

By operating in this fashion, the Council has kept its personal interest paramount and has kept in the background the interest

of the public. Those who stand for public offices and those who undertake a statutory duty must do so at the expense of their personal practice. The Council members cannot argue as they do that they are busy practitioners and therefore cannot come during the week. They must choose either one or the other. It is also no argument to say that if doctors stop their private practice to work on the Council then only mediocre doctors will stand for elections. Perhaps a bit of public spirited zeal can do wonders because the state of the council today is so appalling that it cannot possibly get any worse.

Council members say that their constitution requires them to sit altogether in hearing an enquiry. They, therefore, insist that every enquiry be heard by the full Council. Nothing could be more wrong. It is really a waste of time and duplication of efforts for 15 doctors to sit in on every singly enquiry. Every statutory body has an inherent right to organise its procedures and practices so as to advance the interest of the state as evident from the statute. Every statutory body has the inherent right to organise smaller branches to carry out its business. In the case of the Council although there is no explicit provision permitting the constitution of smaller branches to do enquiries, there is no prohibition as such. The Council, therefore, ought to set up smaller branches of two or three members and distribute the enquiries. If this is done, the complaints before the Council could be expeditiously finished.

Instead of functioning secretively and preventing lawyers and journalists from attending the council proceedings, the council ought to open itself to the public and perform a public interest role. Several voluntary organisations of doctors and others such as the Medico Friend Circle, ACASH and the People's Science Movement have within their ranks and dedicated doctors and social activists who can contribute considerably in the area of medical malpractice. They should be taken as consultants or experts to the Maharashtra Medical Council and should be permitted to actively participate as medico legal aid on behalf of the complainants. As soon as the complainant files a case, on that very day the Council bailiff must go to the hospitals concerned with the complainant and seize all the

medical records and keep them under seal in the Council's office. Journalists should be allowed to attend and report on all proceedings. Enquiries should proceed on a daytoday basis and if this is done, complaints would be disposed off within a couple of months instead of the years that it takes now.

Ultimately it would be far better if the Council itself was abolished and replaced by a proper court where the judges would be retired judges of the high court. The thinking in government circles is along these lines and it is expected that at some stage the Bar Councils, Architect Councils and Medical Councils would be scrapped and replaced by a single court to handle cases of infamous conduct by professionals. Till that happens, litigants will continue to suffer at the hands of Maharashtra Medical Council.

Rot in Medical Council

Case of Maharashtra

Sunil Pandya

Like the Medical Council of India (MCI), the Maharashtra Medical Council (MMC) has little autonomy; the state government calls all the shots. As a result they have set medical education and practice on a course headed towards disaster by such acts as the recognition of private medical colleges that lack even the essential amenities needed to teach medical students.

In a public meeting organised by the Indian Medical Association, two sitting members of the MMC, Drs S N Deshmukh and Jaswant M Mody, acknowledged the great pressure exerted on them by the state government and powerful individuals to recognise such colleges. When pushed into a corner Mody made the following statements. "The MMC insisted inspection (sic) before recognising these institutions. After inspection the MMC did recognise a few of these colleges which met reasonably the requirements of the MCI Act. We also satisfied ourselves that the infrastructure was reasonably comparable to some of the existing medical colleges in Maharashtra ...". Since the term `reasonably' is open to a wide range of interpretations and since it is not specified to which existing medical colleges in Maharashtra he was referring to, we are left in doubt about whether instead of insisting that the new medical college was better than the Seth G S Medical College, the Grant Medical College and other similar colleges, the MMC was content to ensure that it was 'reasonably' like the least reputed existing medical college. Despite being empowered to conduct *suo moto* investigations, the MMC is unable to produce a record of medical malpractices uncovered by it and action taken against unethical doctors in a state where medical malpractice is rampant.

Even with respect to complaints against doctors by patients or their relatives, the MMC has a poor record. I quote but one

example. "I have submitted two complaints to the chairman, Maharashtra Medical Council. Thereafter I sent several reminders to the Council and paid visits to its office a number of times. I have also requested an appointment with the chairman. But there has been no response to both the complaints and requests for appointment. It is now nearly two years since the complaint was made ... and there is no semblance of enquiry let alone result ....".

Where an enquiry is held and the doctor found guilty, the punishment is absurd. The registrar, MMC, sent this letter to a doctor. "In the above complaint ... I am directed by the President, Maharashtra Medical Council to inform you that you are held guilty ... You are therefore strictly warned ... and you should therefore be careful in future in observing the Code of Medical Ethics strictly while practising medical profession...".

All enquiries are conducted in secrecy. The proceedings and outcome are not made known to the medical profession, the press or the lay public. Since the MMC chose to disregard entirely the terrible events at the J J Hospital where several patients died after being given adulterated glycerol, they may also be ignorant of the cardinal principle taught by Justice Lentin when he investigated this tragedy: "An enquiry ... involving no state or defence secret [is] better allowed to unfold itself not within the cloistered doors of secrecy but within full public gaze ... Secrecy breeds suspicion and suspicion breeds contempt ...". Unlike the General Medical Council of Great Britain or other such enlightened bodies, the MMC does not bring out periodic reports of its activities or sponsor thought provoking discussions on burning ethical problems, such as the organ trade, brain death and euthanasia.

With a group of seven other like minded doctors, I decided to stand for election to the MMC in an attempt to improve its functioning. Three of us are full-time members of the teaching staff of a medical college. The form to be filled up by those wishing to stand for election does not contain detailed instructions. As a result, applications were rejected for such reasons as 'The name of the father of the proposer has not been given in full'. Such care when rejecting applications is in sharp contrast to the gay abandon displayed when counting votes (see below).

Approximately 44,000 medical practitioners registered with the MMC are entitled to cast votes. We discovered that the register of the MMC is hopelessly outdated and riddled with errors. Ballot papers were sent to doctors who died five or more years ago. (Their relatives state that they informed the MMC about the demise.) Several doctors in practice, with proof of registration with the MMC, received no ballot papers. Since the maintenance of an uptodate register is one of the prime functions of the MMC, the sitting members were asked to explain these errors. They had no answer.

The MMC has adopted the postal systems for election. Ballot papers are sent by post and are supposed to be returned by post, though envelopes handed in personally are also accepted. The election is thus open to all the malpractices that can attend such a system. Ballot papers can be intercepted and tampered with *en route*. We strongly suspect that such tampering occurred with 2,000 ballot papers at the Girgaum post office that serves the MMC. Legal experts consulted by us expressed surprise that the medical profession does not follow the example of voting booths as adopted by the Bar Council. As a statutory body, the MMC can use the machinery of the Government of Maharashtra for such polling.

The process of election presupposes that each voter has one vote which he/she is expected to exercise. No individual, least of all someone standing for election, has the right to cast more than one vote. We noted that some of the candidates standing for election systematically collected thousands of blank ballot papers from voters. Two of them, S N Deshmukh and Jaswant Mody, confessed at an open meeting and in the presence of representatives of press that they had collected blank ballot papers. Deshmukh felt that there was nothing wrong in his collecting blank papers provided doctors handed them over to him of their free will. Were he not to collect these ballot papers, he stated, the votes might have been wasted as a large number of doctors in the state were apathetic towards the election. It was

better that he, as a candidate, votes several thousand times at one election rather than see these votes not exercised. Mody stated that the practice was unethical but "we are victims of the system".

As a direct consequence of the collection of blank ballot papers on a massive scale, of the 19,000 or so votes cast; 10,000 were brought in suitcases by individuals on the last day of voting and accepted by the returning officer without demur. He obviously found nothing strange or offensive in this action. Each ballot paper had to be enclosed in an envelope provided by the MMC. The voter has to sign the envelope before mailing it so that the MMC can ensure its validity. When the votes were being counted, we requested the polling officer, the registrar of the MMC, to verify the signatures. After much argument, he agreed to do this on 13 envelopes chosen at random and the signatures on three of these did not tally. Despite this, he refused to make any more such random checks.

Our written complaint to the registrar on the above malpractices went unanswered. In response to queries by a reporter, he said that he had received my complaint but had "not had the time to examine it". He also stated that he saw nothing wrong in a suitcase full of ballot papers being delivered by an individual on the last day of the election. He would not say if MMC rules permitted individual candidates to collect and deliver ballot papers in bulk. Needless to add, not a single candidate from our group was elected.

Most doctors in the state of Maharashtra are unconcerned about exercising their franchise in the election of members to their profession's sole regulation body. Tens of thousands were willing to hand blank ballot papers to those candidates who chose to collect them. Several candidates mounted a systematic campaign to collect blank ballot papers at considerable personal expense. Having done so, they cheerfully proceeded to mark their choices on these ballot papers, often trading votes with others.

Under the present circumstances, if you wish to ensure success at these elections you have to be prepared to employ one

or more persons who will systematically go around the state collecting blank ballot papers, place a cross against your own name and trade the other blanks with those holding similar papers so that you mark crosses against their names on your blanks and they mark crosses against an equal number of blanks in their hands. Ensuring that the registrar of the MMC is on your side will clinch the issue.

The MMC, and indirectly the medical profession in general, have lowered themselves in the public esteem. Clearly there is something seriously wrong. Politicians doing the same thing would have been accused of fraud. Do doctors expect patients to believe that a Council elected in this manner is capable of disciplining unscrupulous practitioners? They must know they cannot have it both ways, have a council elected by questionable practices and claim that it is capable of taking care of malpractices within the profession?. If the situation is so bad in Maharashtra I shudder to think about the conditions in states such as Bihar and Uttar Pradesh.

The medical profession must awaken to the fact that incompetent, impotent or corrupt Medical Councils, in the states or in New Delhi, spell doom to medical education and to medical practice. However, there are a large number of doctors struggling against the tide of commercialism and we have been encouraged by the supporting letters written by scores of them. It is now time that we get together and make a concerted effort to stem the rot. The government must be made to drastically change the acts governing the state and national medical councils. The number of nominated members must be reduced to a minimum ensuring a clear majority for those elected. Autonomy must be granted to the Councils in their deliberations and actions. They must either be assured of adequate funds or permitted to raise them. Most of all, the proceedings of the councils must be open to the medical profession, press and public at large.

The process of election needs a major overhaul. All announcements by candidates must be barred and any attempt at canvassing for votes should lead to immediate disqualification.

The Council should circulate the brief biodata of each candidate to the voters. Voting must be in person at booths all over the state and carefully supervised so that no malpractice occurs.

The Councils must be made to publicise periodic reports on their activities (including those following *suo moto* investigations, other inquiries and disciplinary action taken) and make pronouncements on all medicolegal and ethical matters of current import. The Council must be made accountable to the medical profession and the public at large.

Patient's Right to Know

M S Venkataraman

Human rights include the right to exist, the right to food, the right to education, the right to vote and the right to equality. Denial of these rights is often due to maladministration and sometimes intentional. Unintentional interference with rights also exist, contributed to, by ignorance. One such is the right of the sick person to know his/her ailment. The ignorance of the patients of his rights to this knowledge, and often the ignorance of the treating doctor too, of the rights of patients, to know about their illness and its management, are still manifest in our country. Sheila Mclean, Director, Institute of Law and Ethics, University of Glasgow in her book *A Patient's Right to Know*, succinctly states, "Recognising the significance of communication between doctor and patient is a fundamental step in generating a therapeutic atmosphere capable of respecting the rights of the individual patient".

The right of a patient to get involved in the management of his disease is fundamental. Unlike in other sciences, the need for invasion of the patient by the doctor is part of his profession, which includes eliciting the history, and going into family background, not to mention the physical invasion which is inevitable when clinical examination and investigations are carried out — the latter with their own inevitable risks — and lastly the therapy itself, be it medical, surgical or otherwise which is again invasive. All these make the relationship between the doctor and patient a personal and sacred one. As Mcclean puts it: "The potential invasiveness of medicine and social and political potential make it an area ripe for rights discourse". On the one hand is the need to withhold the information conveyed to him as a confidential matter (as per the Hippocratic oath); on the other, the doctor has to take the patient into confidence and tell him what he should know.

A patient has an autonomy of his own. Decisions about his health and bodily fate have to be taken with due respect. The

case for this is strong. This was recognised even in 1919. Again one must realise, that a physician dedicates his duty to a patient and subjects himself to liability, if he withholds facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment (Salgo vs Leland 1957). There is hence a need for a 'therapeutic partnership' by a 'give and take' approach between the two parties.

The awareness of these rights on the part of the patient and the doctor, in the developed countries, stand in contrast to the ignorance here, which may be to the disadvantage of both. The patient does not participate in the management of his ailment, and this is not healthy. The doctor too tends to develop a practice marked by a possible indiscipline, if not negligence, which may be confounded by the fact that he does not need to be updated in his knowledge, since no one cares in any case.

The right of the patient to know, however, does not make the doctor shelve his responsibilities, though this may make the patient a victim of law, as often happens in the west. A delicately balanced approach is indicated. Considerable emphasis is placed on the rights of the patient; but too severe a standard may place the entire practice of medicine at risk, by denying clinical freedom (Sidaway vs Bethlehem Royal Hospital Governor and others, 1985). These extremes generate a lot of ill will and possible litigation.

Why should the patient be informed and why should he give consent, are the two questions that stand out prominently. Again what should he be informed and when? Who else should be involved in the information? Are there situations when the information should be kept away from the patient? What is informed consent? How should consent be obtained? If such consent is obtained from a patient under mental stress, is it valid? How should consents be recorded? What should one tell a patient who is terminally ill, say with an advanced cancer? What about consents from minors, mentally deranged persons? These are some of the questions that come up, if one were to study the role of information and consent in the doctor patient relationship.

The Sections 87 to 93 of the Indian Penal Code form the relevant sections where this relationship between the doctor and the patient is dealt with. Section 87 permits a patient above 18 years to give consent expressed or implied to suffer harm by a doer (here the doctor), where the harm is not intended to cause death or grievous hurt. If one were to study this carefully, 'implied' may include, even an act of being taken to the operation table for surgery (though not for a specific type of surgery). In other words, the fact that the patient has been wheeled into the theatre denotes an implied consent since no one will permit it without his volition and free will.

There is no question regarding the need for informing the patient, as to what his illness is. This is mandatory and makes the patient aware of the seriousness or not of his illness, on the basis of which he may take a decision regarding the management of his ailment. Anyone above the age of 18 can give consent according to the IPC Section 87. (It may be stated here that Section 89 IPC, states that a person under 12 years or unsound mind is considered incapable of giving consent, which leads one to conclude that a person over 12 years, can give his consent). In case the patient is too young or mentally unstable to be informed, the information must be passed on to the guardian, or the lawful custodian.

In the US and in Australia, where a patient cannot give consent, the court must do so. In the US an interesting situation arose when compulsory sterilisation of the mentally unfit was challenged in the court of law (Jacobson vs Massachusetts). The challenge failed. "The principles that sustain compulsory vaccination is broad enough to cover cutting the fallopian tubes. Three generations of imbeciles are enough". In this battle between society and the rights of an individual, society prevailed, for the benefit of society at large. Patient information and consent had to be given the go by, since the patient was incapable of a decision and the guardian in law was the state itself, the US. Action can be taken to preserve a life, health or well being, of another, who is unable to give consent. Such an action is said to be privileged by emergency. This information and consent may be in writing, or may be recorded.

A study of section 88 IPC reveals that the doer, who may cause harm (without intention to cause death) does not commit an offence, provided it is done for the person's benefit and in good faith. Such a benefit may imply monetary, physical or mental. A consent is not such a consent if it is given under fear of injury or under a misconception of fact, as stated in section 90. Such a misconception may be one of omission or commission. Incomplete information will be misconception of omission.

This is where informed consent has become significant today. Such an informed consent is obtained on the basis of relevant and complete information regarding the patient and his illness. An informed consent is also a disclosure of information to a patient which enables him to make an intelligent choice, not simply a choice. The next question is as to what are the facts that are needed to make such a choice, and how one accepts whether the choice of the patients has been intelligent or not? Can such a choice made by the patient be always intelligent?

To take an example: a woman may have been admitted for treatment of a lump in the breast, proven to be a cancer, by biopsy. The surgeon may ask her to choose between removal of the lump alone (lumpectomy) and removal of the entire breast (mastectomy). Both are recognised methods of treatment. A lumpectomy, may seem more attractive to the patient, and yet it may not strike her as relevant, that there is a possibility of a higher incidence of local recurrence with this procedure in contrast to a mastectomy. This may hence amount to passing the responsibility to the patient in the matter of taking an important decision, or passing the buck as it were. It would have been safer and better if this judgment had been made by the surgeon, on the basis of his experience and knowledge. This is brought out vividly in another example. A surgeon may try to explain the pros and cons of various types of vagotomy (cutting the vagus nerves in treatment for peptic ulcer) and the post operative patterns of morbidities in the various procedures. In such a situation a surgeon would be fairer if he explains in simple terms and tells the patient as to why he is choosing one particular type of therapy.

It is unfair, to involve the patient in such academic discussions and statistical garbage, about alternative methods of investigations or therapy where even authorities may have differences of opinion. In other words, it might be beyond the patient's comprehension and may be unfair to expect them to take a correct decision. The court in a decision stated that "It is the prerogative of the patient, not the physician to determine for himself the direction in which his interest seems to lie", based on the familiarity of therapeutic alternatives and their hazards. But then non-experts cannot be presumed to know which school of medical thought is correct (Maynard vs West Midland Hospital, 1985). Hence, one feels this may be unfair to the patient. Such a disclosure without understanding is useless and makes a parody of the patients' involvement (Canterbury vs Spence, 1972).

Delving further into informed consent, should the surgeon tell the patient about his own experience, of success or failure in a particular surgical procedure? His experience in surgery of hernia may show a 10 per cent recurrence which may stand in contrast to another surgeon's 3 per cent recurrence. Does failure to impart this information make him culpable? Can he disclose information against himself, about his own relative (though not absolute) incompetence, though this may still be within acceptable limits in medical fraternity? "Information", says Mclean, "should be to enable the patient not to reject the therapy, but to alert the patient against subsequent difficulties and grief which could be avoided". Obtaining consent on the basis of such information is something more than just legal protection. It accepts, in the bargain, the doctor's acknowledgement of respect for the patients and their decision making.

The mental stress of the patient is another important factor which interferes with his capacity to judge. There have been reports of the patient, developing relative amnesia, of what he discussed earlier with the doctor in this phase of stress. Hence even recordings have been resorted to. These only make the concept of 'informed consent' a little more controversial and of questionable value. One might say, the doctrine of informed consent has become a legal mechanism whose function has been

consent has become a legal mechanism whose function has been simply to expand the liability of the medical profession, to compensate greater number of victims. An extension of the principle of informed consent, may need the doctor to ensure that even non-technical information is not misunderstood.

Sophisticated investigations are costly. Should they be employed? When is it justified to ask for one? These are again difficult questions to answer. The patient has the right to know the benefit he may derive out of the test. He has a moral right to question as to how far the investigations will benefit him, the institute and the referring doctor. Knowing the background of the high percentage of normal reports, there has to be an awareness on the part of the patient, about the relevance of the test in his ailment. The 'inform and consent' principle in medicine has many more facets than apparent. Every investigation, especially invasive ones, must be done only after obtaining informed consent. An intravenous urography, or an angiography, may lead to a dye sensitivity, which may be fatal. A biopsy may lead to its own complication like bleeding, or injury to adjacent organs. Foreseeing such disasters and obtaining written consent about the risk, the patient is willing to take, is not unfair to either party.

Talking of therapy, every drug administration must be with the knowledge of the patient. A dental surgeon supplied penicillin tablets for treatment of dental sepsis to a patient who died shortly after the first dose, of a severe anaphylactic reaction. The tragedy was, that the patient knew she was allergic to penicillin but was unaware that the tablet supplied was penicillin. There are occasions where an anaesthetist enquires about the community of the patient which may be necessary, since some communities have a familial, possible genetic disorder, of developing 'scoline apnoea', a condition of respiratory arrest after administration of scoline, a muscle relaxant.

The doctor must, however, be wary of the enquiries about a patient's health, from relatives near and distant, known and unknown. Such enquiries may not necessarily be with an interest in the welfare of the patient. Even the press may have to be

kept away from the information regarding the health of a VIP in the interestsof the society or the patient himself. The doctor plays a delicate role here, and discretion is advisable.

The patient with an incurable cancer or an irrecoverable condition like a severe heart failure, will pose a problem. Should he or should he not be informed of his illness? Unfortunately, much as it might upset his morale, one cannot help putting all the cards on the table when discussing with him, the nature of his illness, and the treatment contemplated. And, if he were to collapse due to 'shock' consequent to the revelation, is the doctor guilty? Legally he is not, though he he may feel responsible. In such cases he may avert the disaster, by informing a close relative and documenting it.

The information must be regarding the truth, and this includes the whole truth. Failure to warn the patient that vasectomy as a surgery might occasionally fail (which may be due to recanalisation or other causes), and become naturally reversed, amount to a breach of duty of care which the surgeon owed to the patient. Damages were awarded against the surgeon in Thake vs Maurise, (1986). The surgeon could have protected himself by informing the patient about the remote possibility of natural reversal after surgery for vasectomy, however low the incidence. Such full disclosure of material facts in utmost good faith, *uberrimae fidei*, protects the surgeon.

The medical practitioner in India is still a little easy in his approach towards this issue of information and consent. When a patient asks 'What is wrong with me, Doc?' or 'Should this investigation be done on me?' or again 'Is surgery necessary for me? What are the risks?' and so on, the doctor is duty bound to respond. The patient is not testing the knowledge of the doctor. He is not challenging his capacity in his profession. He is genuinely worried about his illness and is anguished. It is the duty of the doctor to satisfy the patient and make him feel more easy. An honest provision of information presented in a polite, humane way to enable the patient to determine the line of action he should take, will benefit him and help the doctor also to proceed further in the management of the problem. Each time

the doctor visits the patient, this principle of information should be extended. We cannot accept benefits without recognising the risks. Both the doctor and the patient must be aware of this. They must, in their best interests, become mutually trusting therapeutic partners. The doctor is acting as a guardian of the patient and this holds good till his cure.

Consumer Protection Act and Medical Profession

Arun Bal

The Indian consumer movement in the health care sector is at the crossroads. On the one hand there is an increasing awareness of issues and on the other, standards of health care delivery have been deteriorating steadily over the last few years. The budgetary allocation for health has been steadily declining over the years. The resurgence of diseases like malaria have brought to the fore the basic contradictions in our health policy. The plight of the consumers is peculiar. They have to bear the adverse effects of many policy decisions but have no say at all in formulating of policy. Moreover they have no forum to get grievances redressed. An important sector of health care is the medical profession. In fact it is nodal sector of the health care 'industry'.

The situation becomes even more complex in our country due to the different systems of medicine which have been traditionally and historically practised. Regulation of the different systems of medicine is very important. However this aspect has remained neglected over the years. The plethora of medical colleges, mostly ill equipped and started on capitation fees, has complicated the situation further. Consumers are caught in a Catch 22 situation. On the one hand, they have to deal with the powerful combine of ill equipped, uncontrolled, mercenary medical profession, corrupt political leadership, defunct regulatory bodies of the profession, overburdened legal system, and on the other, they have has to face grim health situation and various maladies arising out of it.

The discontent of the consumer has been provided an outlet by the new Consumer Protection Act (COPRA). This act has provided a civilised outlet for the discontent. It has also generated intense controversy in the health care field. COPRA was enacted by the parliament in 1986. This act created consumer councils and other fora to settle the consumer disputes. This act seeks to promote and protect rights of consumers, such as:

1 The right to be protected against marketing of goods which are hazardous to life and property.

2 The right to be informed about the quality, quantity, potency, purity, standard and price of the goods to protect consumer against unfair trade practice.

3 The right to be assured that consumer interest will receive due consideration at appropriate authority.

4 The right to be assured access to a variety of goods at competitive prices.

5 The right to seek redressal against unfair trade practice or unscrupulous exploitation of consumers.

6 The right to consumer education.

These objects are sought to be promoted through setting up of central and state level consumer councils; and consumer commission and forum at district, state and national levels. These bodies, though quasijudicial, have powers of the civil courts for the purpose of this act (Section 13). These include Section 193 and 228 of I P Code, Sec 195; and the Chapter XXVI of Civil Procedure code which has:

Sec 27: Summons to defendants.
Sec 28: Service of summons.
Sec 30: Power to order discovery.
Sec 31: Summons to witnesses.
Sec 32: Penalty for default.

Orders XII & XIX: Impounding documents, orders to file affidavit. Order and power to allow cross examination.

Under COPRA there is no court fee or stamp duty. The complaint can be filed in a specific format as a simple letter. There is a specific time frame in which the disposal of cases is allowed. After the complaint is registered, the notice is sent to the respondent. The respondent has to file the reply within 45 days, failing which ex parte hearing can be held. Any appeal against the order of the forum as Commission has to be filed within 30 days. Provisions of Evidence Act and Limitation Act are applicable. In fact it needs to be stressed that the procedure under this act are *judicial* in nature. The financial ceilings for various bodies created under this act viz, district forum, state and national commissions are as follows:

District forum: Upto Rupees One Lakh.
State Commission: Upto Rupees Ten Lakh.
National Commission: Upto Rupees Forty Lakh.

The National Commission is headed by either a sitting or a retired Supreme Court judge. It has four other members who are persons of ability, integrity and standing and have adequate knowledge or experience of or have a capacity in dealing with problems related to economics, law, commerce, accountancy, industry, public affairs or administration. One of these members is a woman (Sec 20). The State Commission has a sitting or retired high court judge of as president and two other members, one of whom is a woman (Sec 16). Similarly The district forum has a president who is a sitting or retired district judge with two members one of whom is a woman (Sec 10).

Under COPRA the definition of consumer is wide. Any person purchasing goods or indulging in the use of these goods is termed a consumer. For example, a toy is bought by parents for the child. The child becomes consumer of the toy company by virtue of being user of the toy. Similarly if a drug is bought by a patient and even though the payment is made by somebody else, an employer or an insurance company, the patient is the consumer.

Service under COPRA means service of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, boarding and lodging, entertainment, purveying of news etc. However, there are two exclusion clauses: (1) Any service which is availed free of cost. (2) Service of a personal nature (contract of service). These two types of services are excluded from the ambit of the COPRA.

Is the Patient a Consumer?

Is medical service a 'personal service'? The answer to the first question is an unequivocal yes. The consumer of the health care industry cannot be excluded from the act. It is not only

doctors who are involved in health care delivery but also the pharmaceutical industry, the medical equipment companies and other ancillary industries. If the patient is not taken as a consumer then the other sectors involved in health care can also escape the provisions of COPRA.

The answer to the second question is 'no'. The doctor patient relationship cannot be termed as personal service. Contract of service denotes a master servant relationship. Can anyone honestly say the doctor patient relationship is of this type? The doctor patient relationship is a contract for service. A patient seeks doctor's service for professional reasons. In this relationship patient cannot control or dominate the relationship. In case of master servant relationship, a servant can be hired or fired at the master's will! Is a patient in a position to do such hiring and firing? To claim that is so, is to ignore the socio economic realities in the society.

Definition of Medical Negligence

Definition of medical negligence has not changed over decades. 'Failure to exercise reasonable skill as per the general standards and prevalent situation' is termed medical negligence. Therefore, failure to cure, occurrence of infection, complication, even a death, cannot be taken in isolation and termed as medical negligence. The doctor has no doubt a discretion in choosing treatment which he proposes to give to a patient and such discretion is relatively ample in case of emergency (L B Joshi vs T R Godbole 1968, Act 183, p.187).It would be worthwhile to quote here a ruling given by Lord Denning in Roe v/s Minister of Health (1954, 2 QB. 66)

One final word. These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice 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 patient at every point, but we must not condemn as negligence that which is only a misadventure.

In Hatcher vs Black the Law of the medical negligence was explained by Lord Denning as follows:

> Before I consider the individual facts, I ought to explain to you the law on this matter of negligence against doctors and hospitals. Mr. Marvan Evertt sought to liken the case against a hospital to a motor car accident or to accident in factory. That is the wrong approach. In the case of accident on the road, there ought not to be any accident if everyone used proper care; and the same applied in a factory; but in a hospital when one person who is ill goes in for treatment there is always some risk, no matter what care is used. Every surgical operation involves risks. It would be wrong, and indeed bad law, to say that simply because a misadventure or mishap occurred, the hospital and the doctors are thereby liable. It would be disastrous to the community if it were so. It would mean that a doctor examining the patient or a surgeon operating at a table instead of getting on with his work, would be forever looking over shoulder to see if someone was coming up with a dagger; for an action for negligence against a doctor is for him like unto a dagger. His professional reputation is as dear to him as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body. You must not, therefore, find him negligent simply because something happens to go wrong; if, for instance, one of the risks inherent in an operation actually takes place or some complication ensues which lessens or takes away the benefits that hoped for, or if in a matter of opinion he makes an error of judgement. You should only find him guilty of negligence when he falls short of the standard of a reasonably skilful medical man, in short, when he is deserving of censure for negligence in a medical man ....
>
> A practitioner can only be held liable in this respect if his diagnosis is so palpably wrong as to prove negligence, that is to say if his mistake is of such nature as to imply absence of reasonable skill and care on his part regard being paid to the ordinary level of skill in the profession (Nathan, *Medical Negligence*, 1957 edition, pp 43-44).

Lord Denning in Hucks vs Cole (1968, 118 New L J 469) said

> A charge of professional negligence against a medical man was serious. It stood on a different footing to a charge of negligence against the driver of a motor car. The consequences were far more serious. It affected his professional status and reputation. The burden of proof was correspondingly greater. As the charge was so grave, so should the proof be clear.

> With the best will in the world, things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong. He was not liable for mischance or misadventure; or for an error of judgement. He was not liable for taking one choice out of two or for favouring one school rather than another. He was only liable when he fell below the standard of a reasonably competent practitioner in his field so much so that his conduct might be deserving of censure or inexcusable. (Ram Biharilal vs Dr J N Shrivastava, AIR, 1985, MP 150 at pp 157158)

> Counsel for the plaintiff put it in this way, in the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical man at the time. That is a perfectly accurate statement as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man confirms with one of those proper standards then he is not negligent.

Any failure to perform an emergency operation for want of consent amounts to negligence (T T Thomas vs Elisa, AIR, 1987 and Usha vs Dr Namboodiri, 1986 ACJ, 141). A defendant doctor charged with negligence can clear himself if he shows that he acted in accordance with general and approved practice. It is not required in discharge of his duty of care that he should use highest degree to skill. Even mere deviation from normal professional practice is not necessarily evidence of negligence. In Amelia Flounders vs Clement Pereira, the court has enunciated the basic principle of law of medical negligence:

> The law on the subject is really not in dispute. The plaintiff has to establish first that there had been a want of competent care and skill on the part of the defendant to such an extent as to lead to a bad result. The plaintiff has also to establish the necessary connection between the negligence of the defendant and the ultimate death of the plaintiff's son.

In an action for negligence against a doctor the plaintiff has to prove: (1) that the doctor was under duty to take reasonable care to avoid or not to cause damage, (2) that there was a breach of duty on the part of the defendant doctor, (3) that the breach of duty was real cause of damage or such damage was reasonably foreseeable. Thus there is no ambiguity about establishing medical negligence. It is also pertinent to point out again that the burden of proving negligence is on the complainant (patient).

Avenues for Redress

At present the patient as a consumer, has only three avenues for redressal of his/her grievances. S/he can do so under civil or criminal court jurisdiction. However, inordinate delays, cumbersome procedure have resulted in denial of justice to the consumers. The third avenue is the medical councils. They have jurisdiction over the medical profession. However, these councils have been ridden with corruption and have become den of vested interest in the profession. These councils are defunct and are really disgrace to the noble profession. Moreover, the Medical Council Act has no provision for compensation.

Any profession in the civilised society has some social obligations. One of these is to create adequate, efficient system for self regulation. In the absence of such self regulation, the profession can suffer damage to its reputation and credibility. This is what has happened to the medical profession in India today. Apathy, indifference of members of profession towards ethical standards have resulted into a quagmire in which the profession finds itself. Professional organisations like the Indian Medical Association have neglected vital issues and only shown a proclivity to arrange dubious medical conferences in collusion with pharmaceutical industry. Such associations have never raised their voice against malpractice in the profession.

The medical profession perceived COPRA as a threat. Concerted efforts were made to persuade policy makers to exclude medical profession from the ambit of COPRA. What were the arguments?

1 *Doctors are not 'traders' and the profession is based on the trust, faith, etc*: The medical profession has historically been given a high status and the members of the profession have been accorded high respect. Doctors are solely responsible for destroying the trust on which the profession was based decades ago. Doctors indulge in various rackets and extract commissions' from each other. Is this in any way different from being traders? Consumers have to suffer the effect of commercialisation

of the profession. Trust and faith cannot be only one sided. Any healthy relationship based on trust and faith has to be mutual, exclusive of commercial element.

2 *Medical cases are technical and judges cannot make fair decisions:* Under COPRA all the procedures of civil procedure code are applicable. The burden of proof is on the complainant (patient). Doctor can produce his expert witnesses as well as crossexamine complainant's witnesses. All over the world, even in developed countries like the US and the UK, medical negligence cases are decided by judges who have no medical expertise. These decisions are taken as per the evidence produced. Even before the COPRA was enacted, the cases of medical negligence were decided in civil and criminal courts where judges have no medical expertise.

3 *There is no court fee, stamp duty, so there can be frivolous complainants:* The purpose of COPRA is to give avenues of fair, speedy redressal of the consumer disputes. 10 per cent court fee or stamp duty can deny the consumer opportunity to seek the redressal. The COPRA is being amended to provide punishment to the complainant for frivolous complaint. Also it is worth reiterating that COPRA is for all the consumers. Doctors are consumers, too.

4 *If the complaint made by the patient fails, doctor should be compensated by the patient:* In any civilised society, retributive element of justice is frowned upon, eye for an eye, hand for a hand type of justice is an anathema in civilised society. It is also necessary to take into account the percentage of malpractice as compared to percentage of complaints under COPRA or other laws. Similarly as explained earlier COPRA is also for all other consumers. If a doctor, for example, wants to seek redressal under COPRA for a vehicle or medical equipment which costs Rs 4 to 5 lakhs and if such complaint fails, should doctor be asked to pay to the company Rs 45 lakhs for damaging its reputation?

5 *Doctors cannot be tried simultaneously under Medical Council Act and COPRA:* It is a basic principle of law that no

person can be tried for same offence under two statues of laws. If any complaint is pending before any bodies created under Medical Council Act or COPRA or quasi judicial body, then it is not justiceable under any other Act.

6 *Trial under COPRA is 'Summary Trial' and COPRA courts are kangaroo courts.* As explained before, the trial under COPRA is speedy trial and not summary trial. All the procedures of the civil court are followed and this trial has all the sanctity of judicial procedure. COPRA courts are headed by proper judicial authority and hence cannot be called kangaroo courts.

7 *There should be a panel of doctors to give opinion which should be accepted by the COPRA courts:* Again basic principle of any civilised judicial procedure is its openness and opportunity given to both the parties to prove their case. Creating a closed system like having a statutory advisory panel is against the basic principle of law. Also it is impractical. Under COPRA there are district, state and national level courts. There are approximately 460 districts in India and 27 States. So 500 statutory panel will be required for all these districts and states. How practical it is to set up so many panels? It would make procedure unwieldy and leave scope for corruption and malpractice in prevalent socio economic conditions.

8 *Doctors will be forced to resort to defensive medicine leading to increase in cost of health care:* This is purely a defensive reaction on the part of the doctors. The law on medical negligence is very clear. Law does not require that any doctors do such and such tests. It also doesn't question doctors judgement in given circumstances unless it is way beyond reasonable limit. Therefore, there is no necessity for doctors to resort to such an attitude. It is likely to prove counter productive in a third world country like India. Also unnecessary investigations are justiciable as unscrupulous exploitation of consumers under COPRA.

9 *As in the US, there will be cases of compensations of millions of rupees ruining medical profession and creating legal rackets:* As per the amendment of COPRA pending before the parliament, lawyers will be debarred from consumer courts

except (1) when courts require legal help (2) either party desires legal help. In USA decisions of courts at preliminary level are jury decisions. They are given wide publicity. However many of these decisions are reversed in appeal. Consumer courts have financial ceilings and they cannot award any compensation beyond these ceiling.

The Medical Council Act was enacted in 1956. In the last 36 years the profession has done nothing to get it amended or make it more effective. Now that COPRA has been enacted, consumer organisations welcome amendments of M C Act. If the Medical Council Act becomes more effective and offers better redressal avenue than COPRA, then the consumer will take advantage of the Act. There are numerous examples of dual legal statues from the same complaint.

Patients' Rights and COPRA

The rights of patients as consumers of health care industry are practically unknown in our country. Most of the rights which are recognised all over the world are trampled upon with impunity. Patients rights have vital relationship with COPRA because COPRA can be used for effective implementation of patients rights. The American Hospital Association has devised a patient's Bill of Rights which is accepted in many hospitals in America. There is need for developing such a Bill of Rights suitable to our socio economic situation.

The basic principle of 'autonomy' of the patient is central to the concept of patients rights. During the last decade this concept has gained recognition. Historically there have been four models of patient doctor relationship, informative, interpretive, deliberative and paternalistic. Of these, in the interest of society it is necessary to cultivate the health care system which promotes deliberative model of patient doctor relationship. It would be worthwhile to quote a passage from Laws by Plato which is still very much relevant to our situation:

> A physician to slave never gives his patient any account of his illness .... the physician offers some orders gleaned from experience with an air of infallible knowledge, in a brusque fashion of a dictator .... The free physician, who usually cares for free men, treats their diseases first by thoroughly discussing with the patient and his friends his ailment. This way he learns something from the sufferer and simultaneously instructs him. Then the physician does not give his medications until he has persuaded the patient; the physician aims at complete restoration of health by persuading the patient to comply with his therapy.

The deliberative model of doctor patient relationship fosters patients' basic rights as a consumer. For example, the right of information. It is necessary to propagate this model to provide better health care facilities. In fact, failure of doctor-patient relationship is the root cause of many of disputes. If this communication can be improved by adopting deliberative model of doctor patient relationship, then many of the disputes can be resolved at the preliminary level. In this regard it is necessary to implement some changes in the patterns of medical education. It is necessary to teach medical students and ingrain in them the need for communications. Even the most uneducated, backward, person can be communicated the facts of his/her illness if the will to do so is present in the doctor. At present such a will is conspicuously absent. A system of patient's counsellors can be created to improve communication to the patients. There is also a need to educate patients as consumers regarding their responsibilities. Exercising rights without responsibilities can be harmful in any civilised society.

Amendments Required

No legislation is without loophole. COPRA has some deficiencies which need to be corrected in the interest of consumers as well as the society. Under COPRA, goods purchased and used for profit or commercial purpose are excluded from the act. This provision needs to be corrected because it excludes all medical equipment used in hospitals. Defective equipment in health care can cause harm to the consumer leading to complaint against doctors. However as per this provision, the manufacturer goes scot free. Service hired free of cost is excluded from the ambit of COPRA. This, at one stroke, excludes government and municipal hospital doctors, giving rise to discrimination.

At present COPRA does not provide any preliminary scrutiny of complaints before any notice is sent to the respondent. This is necessary to avoid COPRA courts from being burdened with unnecessary complaints and to prevent undue harassment of respondents. The Maharashtra State Commission has already adopted procedure of preliminary scrutiny which has been helpful. Pre trial publicity of cases should be avoided. It can hurt the reputation of respondents. In this connection it is necessary to follow guidelines for legal correspondents in the high courts and the Supreme Court.

It is necessary to stress the need for avoiding unnecessary litigation. If an informal reconciliation machinery can be formed with the help of consumer organisations, then such a litigation can be minimised. Such a machinery exists in some countries. For example, in Japan reconciliation is mandatory in cases under Law of Torts. Cases are taken up by the courts only if reconciliation fails.

It is necessary for the medical profession to undertake serious introspection. It needs to organise the various ethical fora. COPRA is not a calamity. The profession must adopt a positive attitude towards COPRA. In fact it is a blessing in disguise. following suggestions are meant to strengthen the ethical norms and health care delivery.

The standards for treatment for various diseases should be desired. This can be done by various professional associations of each speciality.

Ideal informed consent should be formulated for various procedures treatments and operations.

Ethics committees should be set up in each institution and professional association. These committees should have representatives from doctors, consumers and insurance companies. and should be well publicised.

There is a need to formulate code and standards for private nursing homes Private nursing homes should be graded as per

the care they provide and this fact should be displayed. The nursing homes should be made to add here to these standards. In this regard something similar to Baby Friendly Hospitals scheme of UNICEF can be envisaged.

The system of indemnity insurance needs to be streamlined. At present the insurance companies are arbitrarily increasing the premium. This is nothing short of an insurance scam. Doctors as consumers of these companies should join hands with the consumer organisations to correct the system, as the burden of higher premium will be passed onto the consumers.

Many of the hospitals deal with doctors, both full time and honarary, in an arbitrary manner. This is not in the interest of consumers, because if doctors are penalised for non professional reasons, it affects patients equally. Most hospitals avail themselves of many tax concessions and are therefore accountable to society. At present the doctors and their organisations have failed to react to various actions of these hospitals out of fear of reprisals and short term interest. This needs to be changed. The medical profession must take out active part in raising its voice against irregularities in medical education like capitation fee colleges. This is one of the root causes of deterioration in medical practice.

It is also important for the medical profession to inculcate good ideas and conventions. It is a right of the patient to ask for a second opinion regarding his illness. The medical profession should encourage such healthy ideas. In fact it should be made mandatory in case of certain operations. This practice has been in existence in the US in some states. Many of the studies have reported reduction in the incidence of unnecessary operations after provision for mandatory second opinion was introduced.

Professional organisations should raise the voice against faulty, substandard equipment and hazardous drugs. Simple injection needles and plastic canulae are imported in our country which boasts of satellites and rockets.

The system of group practice needs to be fostered to wean away doctors from malpractice. Many a physician would prefer to join a group practice then enter the profession on wrong footing.

A patients' bill of rights needs to devised in consultation with the various section of health care industry.

COPRA is here to stay. The medical profession cannot wish it away. Medical practice in our country has been mystified and doctors have been put on pedestals over decades and generations. Now that the process of demystification has started it seems to hurt the doctors. However the profession needs to accept the change gracefully in its own interest as well as that of the society. The COPRA is basically meant for system correction. The present controversy has proved that the system of regulation in the medical profession needs to be corrected. The process of system change must continue in the interest of society.

Negligence in Medical Care and Law

Mihir Desai

Although medical negligence claims are an offshoot of industrial capitalism, given the circumstances, the existing negligence law can serve a useful purpose in imposing a certain accountability on the part of the doctor and in providing redressal for injuries. The legislation should thus be seen not just as a reflection of bourgeois ideology but also as a bourgeois democratic right which requires to be extended and expanded.

Medical negligence litigation has in the past two decades risen sharply in England and the US. Especially in the US it has reached such a stage that a strong and active lobby has come up against this. It has also led to the increasing practice of 'defensive medicine' and a rise in doctors' insurance rates. In India, of course, there is no corresponding trend. The Indian law on this aspect, however, slavishly follows the British and the American law. These trends therefore become very relevant in India not only for gauging the potentialities of this type of litigation but also to highlight the positive and negative aspects of this system. Though the medical systems in the US and in UK are very different, complete privatisation in the former while state health services in the latter, the law is virtually identical. These trends cannot be viewed in a vacuum but only in the context of the socioeconomic aspects of medical malpractice liability and the reasons why its development has been stagnant in India.

Of late after enactment of the Consumer Protection Act (CPA), 1986, there has been an increase in medical malpractice litigation in India. Simultaneously a strong doctors' lobby has come up protesting against the applicability of the CPA to doctors. A major public debate has been taking place about the pros and cons of the CPA. Thus the law relating to medical malpractice has for the first time come to the mainstream media attention. The need therefore to clarify the existing legal position is acute. The clarification can be best done only by first

looking into some of the theoretical aspects, which will be followed by a review of the British and American law on the subject.

Medical negligence litigation is a response to the following types of questions. What are the rights of patients *vis a vis* doctors and hospital? 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.

Negligence and Torts

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. 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 person 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 perform 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 by 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

Until now we have talked about minimum standards. But what if a person in fact has knowledge, skill or even superior intelligence? The law will then demand that the person's conduct be consistent with it. Professional persons are not only required to exercise reasonable care in what they do, but also with 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 ensure 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 clearly 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 for. 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 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 a 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.

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. The normal reluctance of doctors to testify against co-professionals has been obstacle to justice in the US and the UK and is likely to be so even in India. Now of course, in the US and the UK doctors also come forward to give evidence on behalf of patients. 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' ie what is customary and usual in the profession.

This, of course, gives the medical profession a privilege denied to others, of setting their own legal 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.

In one of the earliest 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 Appeals 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 flowing 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 1 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 case is significant because 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. 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 US. 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.

Hospital Liability: Can a hospital be made to pay for negligence of doctors, nurses and other staff. This is an issue of great importance in India. Often it is not possible to identify 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. Can one then sue the hospital? Or as it often happens the negligent staff member does not have the means to pay. Can one sue the hospital and recover the compensation?

A case in point in the US 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 worsening and ultimately the leg had to be amputated. 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 them upon their own responsibility, no longer reflects the fact. The present day hospitals, as their manner of operation plainly demonstrates, do far more than furnish 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 placed a direct responsibility on the hospital for the maintenance of an acceptable standard of care for patients. Subsequently, the scope of 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.

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.

A hotly debated issue 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 countries like India, 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. Often it becomes difficult to do so for varied reasons like hiding of information by the doctors. 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, Anderson was admitted to hospital for a back operation. During the operation, the tip or cup of a forceps like instrument (angulated rongekur) broke 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 inculpability 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 dysentery 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 patient had been born prematurely and had been admitted to a special unit where extra oxygen was administered to him over a long period. His eyesight was badly affected as a result of a junior doctor's failure to monitor 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.

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 here is the classical bourgeois democratic ideal of individual autonomy, ie 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 skillfully 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 causal link between the non-disclosure 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. When a doctor feels 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 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.

In spite of making a detailed survey, I could find only three reported cases of medical negligence in India.

The first was decided by the Lahore High Court in 1935. 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 injection of Sulphatab. Later Rao suffered from gangrene and had to have his fingers amputated. His eyesight was affected and he lost his strength. He had never had 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 of whether the doctor had performed the required tests before concluding that there was syphilis. Neither did it try to answer the question as to what caused the gangrene.

The second case was one 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 Pune for treatment. He also substituted splints for the planks. After that, in a taxi, Anand was shifted to Pune. Dr Joshi got him screened and found that he needed pin traction. He was then taken to Joshi's hospital. Joshi asked his assistant, Dr Irani to give Anand two injections of morphia and hyoscine HB at 1/2 hour interval. 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 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, Irani, gave emergency treatment upto 9 pm when the boy died. Joshi issued a certificate saying that Anand had died of embolism.

Joshi was sued. Anand's father contended that 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. 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 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".

The third case was decided by the Bombay High Court in 1975. This case read like a doctor's apology. Philips India had appointed a doctor to give treatment to the employees. One employee contracted small pox 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 in any case 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 of doctors should be interpreted much more narrowly than negligence of others, ie the doctor has to be placed on a high pedestal and held to be negligent only if it is totally unavoidable. Of course, this case is not likely to have any impact on subsequent cases, but still, it shows the attitude of the judges. 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. All the three cases relied only on English law books, by of course picking and choosing what suited the court's convenience.

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. Developments on a similar scale cannot be expected in third world countries. Let us therefore look at the causes which gave rise to Tort Law in developed capitalist countries.

In an 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 unprecedented 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 harmed by me capitalists' indifference or miscalculation.

Capitalism also shapes the experience of injury. It must create a proletariat which must sell its labour for wages to live. 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 non-productive 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, the family is no longer able to care for injury or illness, partly because members must seek employment outside and partly since 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 precapitalist 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 the 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 noncharitable 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 hazards different from those suffered by workers at the workplace or

women at home. The rich can avail of the best medical facilities, equipment and medicines, not so the poor.

Secondly, 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 unsafety. The dynamics 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 threat 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 encourages the entrepreneurs and the professionals 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.

In fact, the medical profession is not even interested in curing patients, only in treating as many as possible. Also the costs of damages are externalised by increased professional fees and insurance. In England, various medical defence societies have been established. If there is a successful claim involving negligence of a hospital employee, the amount will be shared by the authority and society. As regards nurses, the Royal College of Nursing holds an insurance policy, indemnifying every member. So, ultimately the costs are passed on to citizens.

The Tort Law is significant for the reproduction of bourgeois ideology. The fault concept upon which the law was built reinforces a central element of bourgeois ideology: individualism. Predicating

liability upon the offender's fault and denying recovery because of the victim's fault perfectly express the bourgeois belief that each person controls his or her own fate. Tort Law offers symbolic support for inequality, by compensating owners for property damage it upholds the notion of private property and its concomitant i e the person's worth as a tort plaintiff is proportional to the value of the property he owns. Also, by relegating injured employees to worker's compensation, which is limited to a fraction of the lost wages, the law treats workers like pure labour value, implicitly denying that they undergo the pain and suffering for which tort victims are given compensation.

Tort Law assumes that for every pain suffered there is some equivalent pain which will erase it, a pleasure that can be bought with money and, therefore, the judges must simulate a market in sadomasochism by asking themselves what they would charge to undergo the victim's misfortune.

Further, Tort Law treats all relationships as forms of prostitution, the semblance of love exchanged for money: Tort Law thus generalises the feminist critique of marriage. Just as society pays 'pain and suffering' damages to the injured victim who is shunned (so s/he can purchase the commodified care and companionship that will no longer be volunteered out of love and obligation), so it pays damages to those who loved him, compensating them for their lost 'investment' in the relationship (so that they can invest in other human capital).

The primary concern of a socialist alternative should be to ensure that those at risk regain control over the threat of injury and illness: compensation must be subordinated to safety, although the former goal remains important. Even if all defects in the capitalist compensation system are removed, 100 per cent damages etc, two defects are irremediable. First, it would mean spreading the costs across society through a social welfare scheme but does not mean spreading the risk of accidents more equally. Secondly, valuation of injury and illness is still done by the state and not by the people who suffer it. These are the problems in New Zealand where since 1974, in place of negligence they have what is called a 'no fault' compensation system.

A just system should be based on substantative equality. It should respond to all victims. Equality amongst victims would mean response to their needs whether or not their misfortunes were caused by fault or by human actions. The second is that the qualities of wealth and income should not be reproduced in the level of compensation.

It is obvious that Tort Law can develop extensively only in developed capitalist societies, only where there is a strong dominant ideology of bourgeois individualism, extensive and all pervading commodity production (where everything is measured in term of money) and certain minimum standard of living where victims have the 'staying power' in courts, and offenders have sufficient means of payment. This, of course, is not the case with India, where we have a backward capitalist economy. Even then with the growth of capitalism more and more actions in torts are likely to arise.

[For many of the ideas expressed in this article I am deeply obliged to the following works: Richard Able in *Politics of Law – A Progressive Critique*; Hugh Collins, *Marxism and Law*; Fire, *Democracy and the Rule of Law*; Ronald Dwarking, *Taking Rights Seriously*; Paul Philips, *Marx and Engels on Law and Laws*; Pashukanis, *Marxism and Law*; Curran Shopiro, *Law, Medicine and Forensic Science*; Mason and McCall Smith, *Law and Medical Ethics*; Keetortn, *Torts*; Christie, *Cases and Materials on Law of Torts*; Charlesworth, *Negligence*; James, *General Principles as the Law of Torts*; K Bingham, *Modern Cases on the Law of Negligence*.]

Postscript

While we struggled to edit, print and publish this book, the struggle for justice by individuals who have written their experiences continued. There have been a few milestones of achievement. They need to be reported.

But before we report on the achievement, let us count failures so that the former are placed in perspective. The important failure was in Ashwini Rane's (Deepa Parab's) case, as she eventually died this year, in coma, without getting a single hearing for her parents' case for compensation in the consumer court. This was the time when the Mumbai consumer court had decided that in order that it takes up a case of medical negligence, the complainant should produce the opinions of two medical doctors stating that there is a *prima faci* case of negligence involved. A large number of complainants were thoroughly harrassed in getting such medical opinion. Very few doctors are ready to take the 'risk' of antagonising their colleagues. Some just do not want to spend time in such an endeavour. The patients always complained to us that some of their doctor friends examined the medical records, opined that there was negligence by the concerned doctor, but at the end refused to give the same in writing. A family friend of Rane's did considerable running around. We tried to help too. However, we also miserably failed in getting such a certificate in her case for presentation in the court. Due to this lacuna, as the danger of the dismissal of her case from the court was becoming almost a certainty, Ashwini decided to save us embarassment by breathing her last in KEM Hospital.

Her death without getting any redressal might or might not have directly moved the members of the consumer court. But that combined with the pleas of many such cases, consumer organisations and activists pursuaded the court to announce a change in its rule. That the court will now not make it mandatory for the complainant to bring the medical opinion. If necessary, the court would seek such opinion from doctors. But this came too late for Ashwini.

This episode brought to light the gross violation of ethics by the profession. It tells us that, the monopolist doctors are organised in a guild, any of their member breaking the rank is made to suffer

isolation. Apart from that, it is the duty of medical professionals to provide impartial objective medical opinion on the basis of the facts of the case. To deny it, and to create the condition that most of its members feel terror struck in giving such opinion, is a wilful collective denial of service to the needy. This is nothing but a collective violation of medical ethics.

While the task of making the profession uphold ethics is yet to be achieved, Raheja tasted victory in defeat in his case against the Maharashtra Medical Council (MMC). His petition against the MMC's order exonerating doctors against whom he had complained, was heard and decided upon by the Bombay High Court. To his and our shock, his petition was dismissed by the court. Aggrieved by such a judgement, he has now moved the Supreme Court. We believe that he has taken a correct decision. For if he wins, it would change the very way the medical councils are conducting inquiries. Although some of the bias of the council as alleged by him may not go so easily, one thing is certain: his victory would make the inquiries and trials of doctors by the medical councils transparent, providing a better chance for the complainant to succeed.

However, his defeat in the high court also has a measure of victory. For he chose to argue his case not only for himself, but also for all such aggreived patients. He and his lawyers made strong points to pursuade the court that the patient has a right over the medical record. The court agreed and ruled that:

> We are of the view that when a patient or his near relative demands from the hospital or the doctor the copies of the case papers and all the relevant documents pertaining to the patient concerned the hospitals and the doctors may be justified in demanding necessary charges for supplying the copies of such documents to the patient or the near relatives. We, therefore, direct the first respondent, Maharashtra Medical Council, to issue necessary circulars in this behalf to all the hospitals and doctors in the state of Maharashtra. We do not think that the hospitals or the doctors can claim any secrecy or any confidentiality in the matter of copies of the case papers relating to the patient. These must be made available to him on demand, subject to payment of usual charges. If necessary, the Medical Council may issue a press note in this behalf giving it wide publicity in all the media.
>
> (Honorable Chief Justice M B Shah and Justice A V Sawant, the Bombay High Court, in Raghunath Raheja *versus* The Maharashtra Medical Council and others, Writ petition No 5720 of 1991 with Chamber summons No. 2 of 1996, Judgement delivered on January 11, 1996.)

We congratulate Raheja and his advocate Colin Gonsalves for advancing the rights of patients. We hope that this judgement will not remain on paper and will be properly implemented. Of course, the best way to ensure that it becomes a right is by making its extensive use.

Singhi's struggle has advanced, too. As he has explained in his narrative, the hearing of his criminal case in the Esplanade Court against Desai was stayed by the Bombay High Court. He first got this stay vacated and got a favourable judgement saying that the criminal proceeding in the lower court should proceed. But Desai felt aggrieved by the judgement. He moved the high court requesting for questioning of the case itself on the grounds that no *prima facie* case made out. The high court directed him to approach the sessions court. The sessions court heard the case for 10 days continuously but was not convinced of the arguments put forth by Desai's advocate. However, Desai once again approached the high court with Ram Jethmalani as his advocate to argue. Singhi himself in person argued the case. Justice Vaidhyanath, who heard the Desai's applications, dismissed it. So, finally he moved the Supreme Court. On July 8, 1996, he along with two very eminent advocates, Soli Sorabji and Ashok Desai (the latter is now the Attorney General of India), appeared before Justice Faizuddin and Justice Kurdukar in the Supreme Court to argue their case. Singhi appeared in person. The Supreme Court had no hesitation in passing an order in favour of Singhi. The order said that, "We do not find any reason for interference" in the Criminal case No 296/P/1991 pending for hearing before the Metropolitan Megistrate S S Shirke in Court No 23 at Esplanade, Bombay.

Legal hurdles being over, the hearing in the criminal case will now begin in the Metropolitan Magistrate's Court soon. One doesn't know what new roadblocks Singhi will encounter in future. However, it is beyond doubt that he is not going to be satisfied with anything less than justice. We wish him well in his endeavour.

Amar Jesani
Mumbai, July 31, 1996.