Chapter 3

CONCEPT OF CONSUMER RIGHTS AND MEDICAL SERVICES

“The good physician treats the disease; the great physician treats the patient who has the disease.”

William Osler
“The right to health cannot be conceived of as a traditional right enforceable against the state. Instead, it has to be formulated and acknowledged as a positive right at a global level one which all of us have an interest in protecting and advancing.”

Former Chief Justice K.G. Balakrishnan

The other key concept in the study design is ‘consumer protection’. The notion of service in the medical field was affected by the advent of CPA in India. The development led to a change in the approach of both professionals and patients. The important milestones are presented in this chapter.

The development of consumer protection regime is fairly young and may be traced to the Bill of Consumers" Rights of US wherein the recognition of consumer rights commenced at the international level. This Bill recognized four important rights of the consumers, viz. (i) the right to safety; (ii) right to be informed; (iii) right to choose; and (iv) the right to be heard. These rights of the consumers were further strengthened by passing of resolution by UN General Assembly on April 9, 1985, wherein general guidelines were issued by the United Nation General Assembly which included: (i) physical safety, (ii) protection and promotion of consumer economic rights, (iii) standards for the safety and quality of consumers goods and services, (iv) measures enabling consumers to obtain redress, (v) measures relating to specific areas like, food, water and pharmaceuticals; and (vi) consumer education and information program. At the domestic front, the consumer movement started with enactment of the Consumer Protection Act, 1986(hereinafter referred as CPA) which aims to provide “for better protection of interest of the consumers and for the establishment of the quasi-judicial authorities for the settlement of the disputes”.

1 National seminar on the ‘Human right to health’ Organized by the Madhya Pradesh State Human Rights Commission, Bhopal- September 14, 2008


3 Id. at 1-Other four rights added in the document are the ; (i) right to satisfaction of basic needs ; (ii) right to redress ; (iii) right to education ; and (iv) the right to healthy environment .
This Act has primarily given statutory recognition to the rights of the consumers in India. These rights, given in the Act, include:

- the right to be protected against the marketing of goods and services which are hazardous to life and property;
- the right to be informed about the quality, quantity, potency, purity, standard and price of goods or the services as the case may be so as to protect the consumer against unfair trade practices;
- the right to access to variety of goods and services at competitive prices;
- the right to be heard and be assured that consumer interest will receive due consideration at appropriate fora;
- the right to seek redress against unfair trade practices or unscrupulous exploitation of consumers; and
- the right to consumer education.

However, prior to these developments, the concern for protection of consumers’ rights and interests may be located under the Law of Torts which is even now equally effective and enforceable. This section on concepts therefore, attempts to throw light on the relationship of Law of Torts vis-à-vis Consumer Protection with special emphasis on Medical Negligence cases. Consumer protection regime primarily aims to protect against deficiency in services and defect in goods. Thus the discussion shall primarily be around these aspects under the torts law and consumer laws, with sector-specific treatment of consumer cases. The sectors specifically included in this monograph are insurance, transport, banking and finance, medical etc.

3.1 Consumer Rights Defined

One often comes across many people who complain of having been supplied with inferior or adulterated goods for which they have paid full price. Similarly some people are seen grumbling that they have paid full fare but their bus and train seats were very un-comfortable. So many a times people do not get the full worth of their money. Don’t they have a right to get the full value of their money spend for the goods and services they want to avail of? Sometimes, people themselves are

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Rajiv Kumar Khare, LAW OF TORTS, MEDICAL NEGLIGENCE AND CONSUMER PROTECTION, 2010, Bhopal-National Law University, pp.2-3
responsible for the inappropriate goods and services that are provided to them. Many a times, they do not know full details of the products or services they are interested in. Sometimes, they take the delivery of goods or avail of the services without caring for their quality. Is it not their responsibility to give full details of the goods and services required by them? The details about the rights and responsibilities of consumers are as follows,²

**Meaning of Consumerism**
A consumer uses goods and services from time to time. He/She may be having the experience of being exploited by some or the other suppliers. Sometimes they overcharge or supply inferior quality goods and services. It is difficult to stop such exploitation by any consumer single handedly. The intensity of such exploitation may be restricted if consumers become alert and collectively take a stand against such malpractices. Self-effort on the part of consumers for safe-guarding themselves is known as “consumerism”.³

Consumerism refers to a movement by consumers to ensure fair and honest (ethical) practices on the part of manufacturers, traders, dealers and services providers in relation to consumers. The movement may be regarded an attempt by individual consumer activists and consumer associations for creating consumer awareness about the malpractices in the market and finding ways and means to protect their interests. This movement will be successful if consumers are aware of their rights and responsibilities while using goods and services. Various rights and responsibilities of consumers are discussed hereinafter.⁴

**Rights of Consumers**
Today consumers face various problems on account of competition in the market, misleading advertisements, availability of inferior quality of goods and services, etc. Hence protection of consumers’ interest has become a matter of serious concern for the Government as well as public bodies. To safeguard the interest of consumers the government has recognized certain rights of consumers. In other words, if

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³ Id.
⁴ Id.
consumers are to protect themselves from being exploited or cheated, they have to be given certain rights so that they are in a position to ensure that sellers of goods and service providers are more careful in dealing with them, e.g. Business Studies.

One of the rights of consumers is the right to choose. Those who are aware of different varieties of the same product need to be shown to them by the shopkeeper so that they can choose what you like. Sometimes, shopkeepers try to sell a particular brand of product on which they get higher commission on sale. It may not be of the best quality, or it may be available at a relatively lower price. This practice can be prevented if one exercises your right to choose the product and visit other shops if one shop does not have a large variety of the product.

**Right to Safety**

It means right to be protected against the marketing of goods and services, which are hazardous to life and property? The purchased goods and services availed of should not only meet their immediate needs, but also fulfil long term interests. Before purchasing, consumers should insist on the quality of the products as well as on the guarantee of the products and services. They should preferably purchase quality marked products such as ISI, AGMARK, etc. This gives consumers the demand for safety even in medical services.

**Right to be Informed**

It means right to be informed about the quality, quantity, potency, purity, standard and price of goods so as to protect the consumer against unfair trade practices. Consumer should insist on getting all the information about the product or service before making a choice or a decision. This will enable one to act wisely and responsibly and also enable him to desist from falling prey to high pressure selling techniques.

**Right to Choose**

It means right to be assured, wherever possible of access to variety of goods and

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8 Id.
services at competitive price. In case of monopolies, it means right to be assured of satisfactory quality and service at a fair price. It also includes right to basic goods and services. This is because unrestricted right of the minority to choose can mean a denial for the majority of its fair share. This right can be better exercised in a competitive market where a variety of goods are available at competitive prices.

**Right to be Heard**

It Means that consumer's interests will receive due consideration at appropriate forums. It also includes right to be represented in various forums formed to consider the consumer's welfare. The Consumers should form non-political and non-commercial consumer organizations which can be given representation in various committees formed by the Government and other bodies in matters relating to consumers.

**Right to Seek Redressal**

It Is the right to seek redressal against unfair trade practices or unscrupulous exploitation of consumers. It also includes right to fair settlement of the genuine grievances of the consumer. Consumers must make complaint for their genuine grievances. Many a times their complaint may be of small value but its impact on the society as a whole may be very large. They can also take the help of consumer organizations in seeking redressal of their grievance.

**Right to Consumer Education**

It is the right to acquire the knowledge and skill to be an informed consumer throughout life. Ignorance of consumers, particularly of rural consumers, is mainly responsible for their exploitation. They should know their rights and must exercise them. Only then real consumer protection can be achieved with success.  

These rights have a historical background.

**3.2 Historical Background**

Consumer Rights in India

Consumer rights were recognized broadly in many ancient Hindu, Islamic and Christian religious scriptures; however, no literary work formalized them into a concise set until the 1960s. Consumer rights in India and the modern world owe their origin to the consumer revolution of the pre-60s in the United States of America.

On March 15, 1962, US President John F Kennedy made a historical speech about consumer rights as he introduced 'The Consumer Bill of Rights' in the US Congress. Ever since, countries all over the world have celebrated March 15 as the Consumers’ Day. However, in India December 24 is celebrated as the National Consumer Day since the Consumer Protection Act, 1986 was enacted on this day by the Indian Parliament.

Kennedy strongly believed that it is vital to United States’ National Interest to ensure the welfare of the consumers, as it is the consumer who fundamentally drives the economy. He formulated four rights for consumers, namely the right to safety, right to choose, right to information and right to be heard which, in 1985, was accepted by the United Nations (UN). The UN added to this list the right to basic needs, right to representation, right to consumer education, and right to healthy environment.\(^\text{10}\)

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

The earliest Indian civilization known to us is the Indus Urban Culture of 3000 to 2000 BC. The archaeological evidence shows that these cities had well-planned drainage system, almost all houses had bathrooms, many houses had latrines and most houses had wells for water supply. The renowned medical historian Henry Sigerist (1987: 142-3) believed that public health facilities of Mohenjo Daro were superior to those of any

other community of the ancient Orient. Unfortunately, there is not much evidence on the way these societies were governed and the kind of entitlements provided by the state or the community to the individuals and the households.\textsuperscript{11}

However, the extent of development of public health system points to some kind of state or community planning which enabled the citizens to get entitlement to hygienic public health arrangements.

The written evidence of the state's involvement and the regulatory function is available from the Kautilya's \textit{Arthashastra}. Kautilya considered famine as a bigger calamity than pestilence and epidemics, as the remedies can be found for the diseases. He believed that the king should order the physicians to use medicine to counter epidemics. The \textit{Arthashastra} also makes mandatory for the doctor to report to the state whenever the doctor is called to a house to treat a severely wounded person. This also applied to treating the one suffering from unwholesome food or drink. Such immediate reporting was mandatory in order not to get accused by the crime committed by such patients. If the doctor failed to provide information to the state, he would be charged with the same offence committed by such patient.\textsuperscript{12}

For not providing proper information to patient, for committing mistake in and for being negligent in treatment, the \textit{Arthashastra} provides for punishment, fine, for the doctor and compensation for victims \textit{Arthashastra} is replete with prescriptions of so-called medieval punishments, including strong recommendations for using torture for getting information or confession, and even using it for punishment. While in the field of ancient medical ethics and laws, the code of Hammurabi prescribing "eye-for-eye" punishment for the doctor injuring patient in the treatment is well known, the punishments prescribed and practiced in Kautilya's time are less known and talked about. \textit{Arthashastra} is a very definitive and practical book. Its identification of each point of state-craft, economic management, infringements and the specific and detailed punishments partly read like a code. It has received less attention perhaps because its writing on the medical practitioners and their duties are part of crisis management, combating recurring famines and epidemics, and also a part of

\textsuperscript{11} Amar Jesani, LAWS AND HEALTH CARE PROVIDERS A Study of Legislation and Legal Aspects of Health Care Delivery, January, 1996, Centre for Enquiry into Health and Allied Themes, Mumbai

\textsuperscript{12} Infra
"consumer" protection in general. When India is still trying to properly codify and implement doctor's duty of giving proper information to the patient, the Arthashastra had made mandatory for the doctor to give prior information about treatment involving life and having consequence of causing injury.

A failure to give such information invited harsher punishment if the patient died or suffered injury. It prescribes the following punishment for "negligence" in treatment: Doctor not giving prior information about treatment involving danger to life with the consequence of Punishment prescribed

- Physical deformity or damage to vital organ, same punishment as causing similar physical injury
- Death of patient lowest level standard penalty (primarily fine)
- Death due to wrong treatment Middle level standard penalty (primarily fine but high amount)

Thus, Arthashastra equated injury due to treatment given without explaining consequences to patient with the similar injury caused in any criminal offence. The death due to wrong treatment invited more penalty than the death as a consequence of correct treatment. Lastly, compensating injury with money, a practice in the present day medical malpractice litigation was known and practiced during Kautilya's time. This is indeed an advance over the Hammurabi type "eye-for-eye" justice system for medical negligence and draws attention to the advancements made by the ancient justice system in India as compared to other countries of that time.\(^\text{13}\) This detailed description shows that state-craft of that time put certain obligations and regulations on the work of doctors. During the Buddha period, there are evidences to show that the state supported University of Taxila, which among other things, provided medical education to students. Bhikshu Atreya taught there and Jivaka was a product of this University. During the Ashoka period (270 BC) the state showed interest in the public works and the provision of medical care. Ashoka founded hospitals all over his empire with medical attendance at state expense. The state also undertook planting of medicinal herbs, planting of trees and supply of potable water from wells along the highways. Ashoka also assisted in the establishment of medical centres in the neighbouring countries. Further evidence on the state's interest in medicine is available.

from the Chinese pilgrim Hsiuan-tsang who studied at the monastic University of Nalanda, which also provided medical education (7th Century AD), The Nalanda University was supported by the revenue collected from more than 100 villages given to it by the King.

The known text books of Ayurvedic medicine took many centuries in getting fully complied. In this process (which also required meeting of scholars and practitioners) the state extended support from time to time. It is suggested that these texts emerged in real fixed form in the first five hundred years AD Around the 12th century AD the Muslims brought their own physicians with them and thereby introduced a new system of medicine knows as, "successful practitioners were those who served successful rulers and, either through regular service or because of some special healing act were granted an area of land. These grants may have been supposed to fund specifically medical activities -a dispensary or a small medical school- or they may have been grants to the man and his heirs, even if they ceased practicing medicine." has documented medical relief in Medieval South India and noted that both state and religious institutions often subsidized and supported medical care.\textsuperscript{14}

There has not been serious and sustained attempt in our country to document the system of self-regulation of physicians and the state laws to protect people from the misdeeds of physicians in these periods. Chattopadhyay\textsuperscript{15} discusses ethics in the Charaaka-Samhita, while Sinha\textsuperscript{16} has argued that "the Ayurvedic physicians of ancient India had a well defined medical ethics". Similarly, Pandya\textsuperscript{17} has summarised various aspects of medical ethics prescribed by Charaaka, Susruta and other Indian physicians. On the other hand, there is almost no sustained evidence on state's special or direct interest in regulating medical practice or the medical practitioners. However, the situation started changing from the British period in the modern history.\textsuperscript{18}

The colonial power brought with it its own physicians and barber surgeons. In the mid-19th century, as the medicine got recognized in England, it slowly started having its

\begin{footnotes}
\item Id.
\item (1977:21)
\item (1983: 266)
\item (1995)
\item Supra note 13
\end{footnotes}
impact in India, too. Further, the public health campaigns, the increasing intervention of the state in the provision and regulation of health care, establishment of hospitals and above-all the development of scientific medicine gradually led to the establishment of what we know as the organized health care service systems all over Western Europe. However, the colonial power was not interested in making the necessary investment in developing such well-organized health care and public health campaigns for its subjects. After 1857, the main factors\(^{19}\) which shaped colonial health policy in India were its concern for the troops and the European civil population. The genuine public health measures remained confined to the well planned cantonment areas housing British people. She has also documented that for the general population the sanitary measures were started in ad hoc fashion for pilgrim centres but the realization that they would be very expensive made the colonial government shelve the programme under various pretexts. She also contends that as the era of sanitary reform was superseded by the professionalization of medicine in England, the colonial government shifted the focus from the sanitary reforms to public health research in India.\(^{20}\)

Nevertheless, the colonial government could not confine its support to health care only in its well organized cantonments. For various reasons, it had to make some provision of health care for the masses, too. For instance, in a study by Muraleedharan\(^{21}\) of the "Rural Health Care in Madras Presidency: 1919-39", he finds that the colonial state had established dispensaries and hospitals for the people, more in the urban areas but less in the rural areas. In 1924 it introduced a scheme called Subsidized Rural Medical Relief Scheme (SRMRS) which was intended to subsidize private practitioners who agreed to settle down in villages. Such private practitioners were not considered government servants, were required to settle down in the villages specified by the local boards and were asked to treat the "necessitous poor" free of charge. However, this scheme was only partially implemented. Despite such inadequacies in implementation, it was in this period that the establishment of a nation-wide formal and organized health care system was started.\(^{22}\)

\(^{19}\)Radhika Ramasubban (1982, also 1985)
\(^{21}\)(1987)
\(^{22}\)Id.
This process of establishment of health care system also necessitated creation of legislative framework for it and for the practitioners of medicine. In its earlier period of rule, the physicians and surgeons brought by the East India Company and after 1857 by the British government, needed some discipline and regulations. Lt. Colonel D.G. Crawford's "A History of Indian Medical Service, 1600-1913" narrates several instances of in-discipline, insubordination, malpractice etc by such doctors and the punishment (including deportation) meted out to them. It also narrates the regulations devised by the East India Company for the hospitals established by it.\textsuperscript{23}

After the enactment of the law establishing General Medical Council in 1857 in England, the British doctors employed in India were registered with the GMC and came under its disciplinary regulation. As the number of doctors qualified in Indian medical colleges increased, creation of laws for them became necessary. Similar development took place for the nursing profession. A brief history of the legislation enacted for health care professionals is given in the subsequent discussion.\textsuperscript{24}

The connected notion of Consumer protection was always a matter of great concern. In ancient India, effective measures were initiated to protect consumers from crimes in the market place. Ancient law givers ably described various kinds of unfair trade practices and also prescribed severe punishments for wrong doers. Mainly, acts of adulteration and false weights and measures were seriously dealt with. In ancient India, the king was the supreme authority to render justice, but his authority was circumscribed by the rules of Dharma. In the medieval period, some Muslim rulers developed well organized market mechanisms to monitor prices and the supply of goods to the markets. During the British period, the modern legal system was introduced in India and many laws were enacted to protect the interests of consumers generally. Today, the civil justice system is tainted with deficiencies that discourage the consumer from seeking legal recourse.\textsuperscript{25}

\textsuperscript{23} Supra note 20  
\textsuperscript{24} Amar Jesani, Right to health care, entitlement and law:Laws and health careproviders, Report 1996, CEHAT,pp. 12-14  
In conclusion, it is clear that ever-increasing consumer protection seems to be the order of the day. This now includes the injured bystander remedies and damage to goods. The new type of products liability litigation in which attorneys will increasingly be engaged will no longer be limited to breach of warranty, negligence or strict liability.

3.3 International Perspective

‘A charter of rights and standards for health care consumers is what’s needed to ensure that the entire system benefits by becoming more accountable to the citizens who pay for it and more responsive to the consumers who need to use it.’

Consumer Protection: International Scenario: The need for consumer protection at international level was also echoed in the thought that consumerism was largely invented by Mr. Ralph Nader, the well-known American Advocate. History of protection of Consumer’s rights by law has long been recognized dating back to 1824. Every year the 15th of March is observed as the World Consumer Rights Day. On that day in 1962, President John F. Kennedy of U.S. called upon the U.S. Congress to accord its approval to the Consumer Bill of Rights.

They are (i) right to choose; (ii) right to information, (iii) right to safety and (iv) right to be heard. President Gerald R. Ford added one more right i.e. right to consumer education. Further other rights such as right to healthy environment and right to basic needs (Food, Clothing and Shelter) were added.

In the history of the development of consumer policy, April 9, 1985 is a very significant date for it was on that day that the General Assembly of the United Nations adopted a set of general guidelines for consumer protection and the Secretary General of the United Nations was authorized to persuade member countries to adopt 3 General Assembly Resolution 39/85; these guidelines through policy changes or law. These guidelines constitute a comprehensive policy framework outlining what governments need to do to promote consumer protection in following seven areas:

- Physical safety;
- Protection and Promotion of the consumer economic interest;

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26 Kate Moore, A Health Consumers’ Charter, Health Forum 1993 (As mentioned in- The role of a health rights charter in improving safety and quality in health care – February 2008)
• Standards for the safety and quality of consumer goods and services;
• Distribution facilities for consumer goods and services;
• Measures enabling consumers to obtain redress;
• Measures relating to specific areas (food, water and pharmaceuticals) and
• Consumer education and information programme.

Though not legally binding, the guidelines provide an internationally recognized set of basic objectives particularly for governments of developing and newly independent countries for structuring and strengthening their consumer protection policies and legislations. These guidelines were adopted recognizing that consumers often face imbalances in economic terms, educational levels and bargaining power and bearing in mind that consumers should have the right of access to non hazardous products as well as the importance of promoting just, equitable and sustainable economic and social development. These U.N. guidelines for Consumer Protection can assist in the identification of priorities particularly in the light of emerging trends in a globalised and liberalized world economy.

The U.N. guidelines were never intended to be a static document and required to be revisited in the changed social, political and economic circumstances. On reexamination of U.N. guidelines in 1999 “sustainable consumption” was also included in the list which is certainly an important step in this direction. It would perhaps be apt to highlight the long back Mahatma Gandhi said that” the rich must live more simply so that the poor may simply live.” There cannot be a better expression championing the cause of sustainable consumption. The increased internationalization of cooperation is also a part of the globalization process. Rules adopted for corporations trading in OECD countries for the protection of the interests of consumers can now also be applied to their conduct for the protection of the interests of the consumers in non-OECD countries. A new investment guideline from the OECD spells out principles to be applied by multinational corporations dealing with consumers. The Guidelines, which deal with fair business, marketing and advertising practices as well as safety and quality of goods and services lend themselves to consumer monitoring and campaigning. Possibilities for action include twinning arrangements in which groups from non-OECD countries work with groups from the home countries of multinational
corporations to hold them accountable for failure to adhere to the Guidelines.27

‘The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being…Promoting and protecting health and respecting, Protecting and fulfilling human rights are inextricably linked.'28

The Protection of consumer rights is now a global agenda. Bangladesh, a third world country, is struggling to fulfill the basic needs of its population. “Socialism meaning economic and social justice”, a fundamental principle of the state policy and the Constitution is yet to be implemented although 38-years have already passed from its Independence. The world economic giants have enacted a series of Laws on different heading to meet the contemporary global demand on economic progress in one side and protection of the consumers from unfair, misleading and aggressive business propaganda on the other. The United Nations (UN), European Union (EU) and World Trade Organizations (WTO) have adopted a lot of rules to regulate trade and business of various products and services through import or export that impacts seriously on producer or manufacturer, supplier or distributor, seller and ultimately to the consumer. Bangladesh, a country with over population, has enacted “Consumer Rights Protection Act, 2009” to deal with the consumer affairs. The law is an addition to a number of around 61 relevant Laws dealing with the consumer rights and their protection mechanisms in a sporadic way.29

**Aspects of Consumer Protection**

In Bangla Desh, the concept of Consumer Protection is discussed in following way

“There are three aspects of consumer rights protection, which every country must consider.


Voluntary Protectionism

Institutional Protectionism

Statutory Protection

First, the aspect of 'voluntary protection' which means that consumers themselves would voluntarily set up associations and/or organizations to safeguard their own rights and interests. These associations/organizations generally work as pressure groups on the government for consumer rights issues e.g. the Consumers' Association of Bangladesh (CAB).

Second, the aspect of 'institutional protection'. By establishing national institutions to safeguard and promote consumer rights of citizens this aspect of consumers' protection can be ensured. In Bangladesh Standard and Testing Institute has been active in protecting consumers of Bangladesh in a limited capacity by way of doing laboratory research and testing of commodities to find out whether the same comply with the expected standard. However, currently the country has established a “National Council for the protection of Consumer Rights” and a „District Committee“ in every district headed by the DC's. The Consumer Rights Protection Act, 2009 has also established a Department/Directorate headed by a Director General (DG) for the protection of consumer’s rights. Except the Government institutions there are some Non-Government Organizations (NGO's) working for the protection of consumer rights e.g. CAB, Adhunik, PAB, BAPA etc.

Third, the aspect of 'statutory protection’ can be guaranteed by enacting relevant laws for protecting the rights and interests of the consumers. Many countries of the world, including those in Asia, have already enacted comprehensive laws in this regard, for example, the Consumer Rights Protection Act, 2009 in Bangladesh.

So, the concept of consumer rights depends upon the promotional activities and the protection mechanisms of a particular society or of a state. The protection of a consumer rights ultimately ensures safety in products and security in service whereas the promotion of a consumer rights depends upon the education, monitoring of the supply and marketing systems of various products, examining goods, enforcing proper scale in weight and measurement, enacting proper laws, creating awareness,
In summary, there are three types of protections, voluntary, institutional and statutory, that are responsible for protecting consumers.

**Concept of Consumer Protection**

Consumer protection consists of laws and organizations designed to ensure the rights of consumers as well as fair trade competition and the free flow of truthful information in the marketplace. The laws are designed to prevent businesses that engage in fraud or specified unfair practices from gaining an advantage over competitors and may provide additional protection for the weak and those unable to take care of themselves. Consumer protection laws are a form of government regulation which aims to protect the rights of consumers. For example, a government may require businesses to disclose detailed information about products—particularly in areas where safety or public health is an issue, such as food. Consumer protection is linked to the idea of "consumer rights" (that consumers have various rights as consumers), and to the formation of consumer organizations, which help consumers make better choices in the marketplace and get help with consumer complaints.

Other organizations that promote consumer protection include government organizations and self-regulating business organizations such as consumer protection agencies and organizations, the Federal Trade Commission, ombudsmen, Better Business Bureaus, etc.

A consumer is defined as someone who acquires goods or services for direct use or ownership rather than for resale or use in production and manufacturing. Consumer interests can also be protected by promoting competition in the markets which directly and indirectly serve consumers, consistent with economic efficiency, but this topic is treated in competition law. Consumer protection can also be asserted via non-government organizations and individuals as consumer activism.

The necessity of adopting measures to protect the interest of consumers arises mainly

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30 Id.
31 See en.wikipedia.org/wiki/Consumerprotection
due to the helpless position of the consumers. There is no denying fact that the consumers have the basic right to be protected from the loss or injury caused on account of defective goods and deficiency of services. But they hardly use their rights due to lack of awareness, ignorance or lethargic attitude. However in view of the prevailing malpractices and their vulnerability there to, it is necessary to provide them physical safety, protection of economic interests, access to information, satisfactory product standard, and statutory measures for redressal of their grievances. The other main arguments in favour of consumer protection are as follows:

(a) Social Responsibility
The business must be guided by certain social and ethical norms. It is the moral responsibility of the business to serve the interest of consumers. Keeping in line with this principle, it is the duty of producers and traders to provide right quality and quantity of goods at fair prices to the consumers.

(b) Increasing Awareness
The consumers are becoming more mature and conscious of their rights against the malpractices by the business. There are many consumer organizations and associations who are making efforts to build consumer awareness, taking up their cases at various levels and helping them to enforce their rights.

(c) Consumer Satisfaction
Father of the Nation Mahatma Gandhi had once given a call to manufacturers and traders to “treat your consumers as God”. Consumers’ satisfaction is the key to success of business. Hence, the businessmen should take every step to serve the interests of consumers by providing them quality goods and services at reasonable price.

(d) Principle of Social Justice
Exploitation of consumers is against the directive principles of state policy as laid down in the Constitution of India. Keeping in line with this principle, it is expected from the manufacturers, traders and service providers to refrain from malpractices and take care of consumers’ interest.

(e) Principle of Trusteeship
According to Gandhian philosophy, manufactures and producers are not the real owners of the business. Resources are supplied by the society. They are merely the trustees of the resources and, therefore, they should use such resources effectively for the benefit of the society, which includes the consumers.
(f) Survival and Growth of Business

The business has to serve consumer interests for their own survival and growth. On account of globalization and increased competition, any business organisation which indulges in malpractices or fails to provide improved services to their ultimate consumer shall find it difficult to continue. Hence, they must in their own long run interest, become consumer oriented.\(^{32}\)

**Patient rights in New Zealand**

The Medical Council of New Zealand has enforced the Code of Rights under a separate law under the Health and Disability Act 1994 (the HDC Act). Patients have rights as consumers of health and disability services provided by doctors and other health professionals in public and private services, for paid and unpaid services, within hospitals and within private practices. The code of rights is law under the Health and Disability Act 1994 (the HDC Act).

The rights of patients can be summarized into 10 points:

1. Consumers should always be treated with respect.
2. No one should discriminate against consumers, pressure them into anything, or take advantage of them.
3. Services should help consumers to live dignified, independent lives.
4. Consumers should be treated with reasonable care and skill and receive well coordinated services.
5. Service providers should listen to consumers and give them information in a way they can understand and that makes them comfortable to ask questions if they don’t understand. This may require the services of an interpreter.
6. Consumers should have any treatment explained to them, including benefits, risks, alternatives, and costs, and have any questions answered honestly.
7. Consumers can make their own decisions about treatment, and are free to change their mind.
8. Consumers can have a support person with them at most times.
9. All these rights apply if consumers are asked to take part in research or teaching.
10. Consumers have a right to make a complaint and have it taken seriously.\(^{33}\)

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\(^{32}\) Consumer Protection, Business Studies, Module on Marketing (2004); Chap. 24, pp. 199-200

The rights of patients in Zimbabwe

The Patients Charter was developed from recommendations by the Consumer Council of Zimbabwe (CCZ) and the Ministry of Health and Child Welfare to offer protection to consumers and improve health service delivery. The Charter therefore spells out general consumer rights to access and treatment.

Patients Rights can be described as social and individual rights. Social rights cover aspects such as the quality and accessibility of health care, while individual rights relate to basic human and consumer rights.

1. GENERAL RIGHTS TO ACCESS AND TREATMENT
Patients have a right to access the Health System at the time of need, both as non paying and paying patients. In the event that a patient has contact with the Health Service, it is important for them to remember that the Health Service is there to respond to their needs. Below are some of the rights, patients need to understand.

1.1 Hospitality (Health Care)
A patient has the right to be accorded courtesy and to be treated with respect in a safe and clean environment.

1.2 Confidentiality
Save for the requirements of the law, all information concerning a patient’s illness or personal circumstances will be kept in confidence and used only for the purposes of their treatment. A patient has the right to details of his/her treatment and diagnosis.

1.3 Privacy
A Patient has the right to privacy during consultation, examination and treatment. A patient shall therefore be interviewed and treated in surroundings designed to ensure privacy and shall have the right to be accompanied during any physical examination or treatment if they so wish.

1.4 Discrimination (Human Treatment)
A patient has the right to be received and attended to without regard to sex, age, religion, colour, creed, tribe, race and socio-economic status. This also means that optimal health care must be provided to all citizens at the right cost.

1.5 Choice
A Patient must exercise their right to choose health workers who provide them with treatment or advice, the place and type of treatment that is provided. After being informed of the possible options, patients have the right to refuse or halt any medical interventions. Patients are also allowed to seek a second opinion at any given time while consulting the same medical or health care delivery system.

1.6 Redress of Grievances
Patients shall have access to appropriate grievance handling procedures. They have the right to claim damages of injury or illness incurred or aggravated as a result of the failure of the health professional to exercise the duty and standard of care required of him or her while treating them. Patients shall have the right to legal advice as regards any malpractice by health care professionals.

2 SERVICES
2.1 Admission and Stay in Hospital
In the event of an accident or emergency, patient will be attended to by a Health Worker immediately upon arrival, assessed and dealt with appropriately. Whether patient is admitted as an emergency or not, hospital staff shall inform your relatives or next of kin or whoever you wish, was practicable. Keep patient kit and valuables in a safe and clean place. Give patient clear information about his/ her illness and condition and the treatment plan for your recovery.

2.2 Consent
In some cases, treatment might necessitate the need for operative procedures. This is an unnerving experience for most patients. In the event that surgery is anticipated in your treatment plan, you have the right to be consulted and to be informed about the nature of the operation. Where risks are known, patient will be informed.
If patient is 18 years of age and above, you have the right to give your consent to surgery recommended by health workers.
If patient is 17 years of age and below, your parent or guardian will give this consent. However, where patient is incapacitated and therefore unable to give patient’s consent, health workers have a moral and ethical duty to do everything possible to save patient’s life first.
Patient has a right to give your consent to any research which teaching staff wishes to carry out on/with patient.³⁴

**Consumer rights and responsibilities in United States**

In United States, in March 1998, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry issued its final report, which included the Consumer Bill of Rights and Responsibilities. The Commission was appointed by President Bill Clinton, and co-chaired by Donna Shalala, Secretary of the Department of Health and Human Services.

The purpose of the Bill of Rights is:

- To build up consumer confidence in the health care system, by making it easy for consumers to participate actively in their own health care.
- To strongly support the importance of a good healthcare provider and that of a good provider-patient relationship.
- To emphasize and support the importance of the consumers’ role in making sure they have rights and responsibilities with regard to health improvement.

The following section, Consumer Bill of Rights, was developed by the federal government. This has been used as a foundation for many health plans, including the federal-government-sponsored health plans.

**Consumer Bill of Rights**

I. Information Disclosure

You have the right to receive accurate and easily understood information about your health plan, health care professionals, and health care facilities. If you speak another

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language, have a physical or mental disability, or just don’t understand something, assistance will be provided so you can make informed health care decisions.

II. Choice of Providers and Plans

You have the right to a choice of health care providers that is sufficient to provide you with access to appropriate high-quality health care.

III. Access to Emergency Services

If you have severe pain, an injury, or sudden illness that convinces you that your health is in serious jeopardy, you have the right to receive screening and stabilization emergency services whenever and wherever needed, without prior authorization or financial penalty.

IV. Participation in Treatment Decisions

You have the right to know all your treatment options and to participate in decisions about your care. Parents, guardians, family members, or other individuals that you designate can represent you if you cannot make your own decisions.

V. Respect and Nondiscrimination

You have the right to considerate, respectful and nondiscriminatory care from your doctors, health plan representatives, and other health care providers.

VI. Confidentiality of Health Information

You have the right to talk in confidence with health care providers and to have your health care information protected. You also have the right to review and copy your own medical record and request that your physician amend your record if it is not accurate, relevant, or complete.

VII. Complaints and Appeals

You have the right to a fair, fast and objective review of any complaint you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the conduct of health care personnel, and the adequacy of health care facilities.

Consumer Responsibilities

In addition to outlining consumer rights for health care, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry also outlined guidelines
for the responsibilities that the consumer has with regard to their own healthcare. The responsibilities outlined are ways that the consumer can work together with the health care provider to achieve the best quality health outcome.

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Become involved in specific health care decisions.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal process to address concerns that may arise.
- Avoid knowingly spreading disease.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about his or her health plan coverage and health plan options (when available) including all covered benefits, limitations and exclusions, rules regarding use of information, and the process to appeal coverage decisions.
- Show respect for other patients and health workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of the health plans and health care providers.
- Report wrongdoing and fraud to appropriate resources or legal authorities.\(^{35}\)

**The Australian Charter of Healthcare Rights**

The Australian Charter of Healthcare Rights describes the rights of patients, consumers and other people using the Australian healthcare system. These rights are essential to make sure that, wherever and whenever health care is provided, it is of high quality and is safe.

Healthcare rights are the rights of patients, consumers and other people using healthcare services. The Charter recognizes that people receiving care and people

\(^{35}\) *Consumer Rights and Responsibilities, Medline Plus* (A service of the U.S. National Library of Medicine National Institutes of Health)

providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding principles

These principles describe how this Charter applies in the Australian health system.

1. Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2. The Australian government commits to international agreements about human rights that recognise everyone's right to have the highest possible standard of physical and mental health.

3. Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences. 36

Patients' rights vary in different countries and in different jurisdictions, often depending upon prevailing cultural and social norms. Different models of the patient-physician relationship—which can also represent the citizen-state relationship—have been developed, and these have informed the particular rights to which patients are entitled. In North America and Europe, for instance, there are at least four models which depict this relationship: the paternalistic model, the informative model, the interpretive model, and the deliberative model. Each of these suggests different professional obligations of the physician toward the patient. For instance, in the paternalistic model, the best interests of the patient as judged by the clinical expert are valued above the provision of comprehensive medical information and decision-making power to the patient. The informative model, by contrast, sees the patient as a consumer who is in the best position to judge what is in her own interest, and thus views the doctor as chiefly a provider of information. There continues to be enormous debate about how best to conceive of this relationship, but there is also growing international consensus that all patients have a fundamental right to privacy, to the confidentiality of their medical information, to consent to or

to refuse treatment, and to be informed about relevant risk to them of medical procedures.\textsuperscript{37}

Various countries have discussed this aspect of Consumer Protection in detail and came out with consumer rights and responsibilities under different headings. Ultimately the consumer is being respected and his rights are preserved. India is the only country where the Consumer Protection and Consumer rights concept is applied to the Medical Field and implemented at a large scale.

3.3 Development of concept in India

THE PATIENT AS A CONSUMER

Traditionally, patients in India have unquestioning trust in their doctors. Most doctors deserve it. But in some cases, medical negligence has resulted in severe harm physical, mental and financial. In addition, unqualified practitioners have brought suffering to gullible patients. Doctors have been liable to prosecution in civil court, but few malpractice victims sue for compensation, fearing years (even decades) of costly litigation. Fortunately, in 1995 the Supreme Court decreed the medical profession to be a "service" under the Consumer Protection Act; 1986. It set aside a writ Petition challenging the same by the Indian medical Association.\textsuperscript{38}

THE PATIENT'S RIGHTS

In the interest of a healthy doctor patient relationship, A patient should Know his rights as a consumer: This article discusses the patient rights addressing to the patients/ readers for better understanding.

- Patient has a right to be told all the facts about your illness; to have his/ her medical records explained to him/ her; and to be made aware of risks and side effects, if any, of the treatment prescribed for he/ she should not hesitate to question patient’s doctor about any of these aspects.
- When patient is being given a physical examination, he/ she have a right to be handled with consideration and due regard for his/ her modesty.
- Patient has a right to know your doctor's qualifications. If you cannot

last accessed 31 March 2013

\textsuperscript{38} Know your rights, Consumer Guidance Society of India, http://www.cgsiindia.org/nowyourrights.html
evaluate them him/herself, should not hesitate to ask someone who can.

- Patient has a right to complete confidentiality regarding his/her illness.
- If patient is doubtful about the treatment prescribed and especially an operation suggested, he/she have a right to get a second opinion from any specialist.
- Patient has a right to be told in advance what an operation is for and the possible risks involved. If this is not possible because of his/her being unconscious or for some other reasons, his/her nearest relatives must be told before they consent to the operation.
- If patient is to be discharged or moved to another hospital, he/she have a right to be informed in advance and to make his/her own choice of hospital of nursing home, in consultation with the doctor.
- Patient has a right to get his/her case papers upon request.  

In the light of this comparative perspective, the researcher revisits the Indian developments

**Post-independence developments**

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

**Committees on Health Services and their recommendations on health laws:**

At the time of independence, and the first few years of planning, the task confronting the country was to create physical and institutional infrastructure for the rapid development or modernization of India. Consumer protection initiatives by the Government hinge on 3 basic

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39 Supra note 38

41 Id.
parameters. Firstly, ensuring a legal framework that comprises of Consumer Protection Act. Secondly, evolving standards for different products to enable the consumers to make an informed choice about different products. Standards which are the essential building block for quality, play a key role in consumer protection. Standards could be on technical requirement (specifications), improved specific standard terminology (glossary of terms), codes of practice or test methods or management systems standards. The standards are set generally by Government or inter-Governmental bodies but worldwide it is being recognized that voluntary establishment of standards plays an equally important role for protecting consumers. Thirdly, consumer awareness and education is the main building block for consumer protection.\(^4^2\)

Education is the most powerful tool for the progress of the country and is a social and political necessity. Education helps an individual—as a consumer—in making rational choices and protects him from trade and business-related exploitation. But more is needed for the effective functioning of the national market to create an increased level of awareness of consumer rights, and for this consumers have to be educated about rights and responsibilities through concerted publicity and awareness campaigns. In the awareness campaigns, special emphasis needs to be given to vulnerable groups such as women and children, students, farmers and rural families and the working class.\(^4^3\)

**Patients’ rights in India**\(^4^4\)

When one considers the conditions in India, the stark difference between the rights in the US and India is highlighted. The Medical Council of India published, in 2002, a Code of Ethics Regulations (COER) which deals with the duties and responsibilities of physicians in addition to certain rights of patients. It must be emphasized that this code does not represent patients’ rights; those mentioned are incidental to the duties and responsibilities of physicians. A distinction must therefore be made between a duty-centric approach as represented by the COER and the rights-centric approach of the AAPS. A medical professional may have issues with the rights-centric approach of AAPS, but is duty bound to uphold the rights of patients that are incidental to his/her duties.

At the time of registration with the Medical Council of India (MCI), all medical


\(^{43}\) Consumer Protection and Competition Policy, Eleventh Five Year Plan, p.247

practitioners are required to sign a declaration, stating *inter alia* as follows:

“I shall abide by the code of medical ethics as enunciated in the Indian Medical Council”. 45 The Consumer Guidance Society of India (CGSI) has a more comprehensive charter on its website listing eight specific rights of patients. Interestingly, the CGSI’s charter does not include the right to refuse treatment. Thus, if the physician decides on a particular course of action, the patient can at the most ask for a second opinion. Apart from this, the rights of patients are similar in the US and India. However, there is no automatic respect for patients’ rights in India, and if they are violated, the only recourse for patients is to approach the consumer courts. Violation of patients’ rights is not a cognizable offence in India as it is in the US and some other countries. This experience is commonly reported in the media, in journals as well as in informal interactions by patients as well as their friends and close relatives. The differences between the responsibilities described in the COER and each point of the CGSI’s charter of rights may be worth discussing.

- Patient has a right to be told all the facts about your illness; to have your medical records explained to you; and to be made aware of risks and side effects, if any, of the treatment prescribed for you do not hesitate to question your doctor about any of these aspects. Physicians and surgeons rarely have the time or the inclination to discuss with the patient the diagnosis, treatment or the prognosis. In those rare situations where the physician is inclined to do so, the close relatives may attempt to keep the patient in the dark. There is little awareness that the patient’s anxiety can increase manifold in the absence of clear information. This may be particularly true in case of diseases like cancer, where patients and relatives believe that there is little chance of recovery. In many cases the patient or relatives may not understand the modalities of treatment; in any case the physicians are rarely keen to discuss this with them. The COER does address this issue, as it enjoining all physicians to give factual information to patients and their relatives stating: The physician should neither exaggerate nor minimize the gravity of a patient’s condition. He should ensure himself that the patient, his relatives or his responsible friends have such knowledge of the patient’s condition as will serve the best interests of the

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45 Professional Conduct, Etiquette and Ethics) Regulations 2002." (Appendix 1, Declaration, clause k)
patient and the family. Best interest is often a controversial issue and cannot be the same for all patients. This may have to be evaluated on per case basis and differ from patient to patient.

- When patient is being given a physical examination, you have a right to be handled with consideration and due regard for your modesty. This right is most commonly respected, and physicians do their best to protect the patient from undue exposure. Most doctors also empathize with their patients and show due consideration. Patients are respected and treated with great care as a norm, yet, as an exception, violation of this right cannot be ruled out. However, this is not specifically mentioned in the COER.

- Patient has a right to know your doctor’s qualifications. If you cannot evaluate them yourself, do not hesitate to ask someone who can. The unequal nature of the doctor-patient relationship, patients approach doctors when they are in need of help may make patients reluctant to ask their physicians for their qualifications or experience. However, the COER requires that doctors provide this information without being asked, as it states: Physicians shall display as suffix to their names only recognized medical degrees or such certificates/diplomas and memberships/honors which confer professional knowledge or recognizes any exemplary qualification/ achievements.

- Patient has a right to complete confidentiality regarding your illness. The COER supports patients’ right to confidentiality: Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the State. However, in Indian society where the physician may be required to interact with the entire family, and may be asked for information on the patient, physicians are generally willing to discuss the patient’s problems with his/ her relatives, violating this clause.

- If patient is doubtful about the treatment prescribed and especially an operation suggested, you have a right to get a second opinion from any specialist. We may presume that doctors do not discourage their patients from seeking a
second opinion on their advice. However, should a patient seek a second opinion, and if the same turns out to be radically different from the first, the patient is in a quandary as to which opinion to accept. The COER supports the right of the patient to take a second opinion, but adds as follows: Differences of opinion should not be divulged unnecessarily but when there is irreconcilable difference of opinion the circumstances should be frankly and impartially explained to the patient or his relatives or friends. It would be open to them to seek further advice as they so desire.

- Patient has a right to be told in advance what an operation is for and the possible risks involved. If this is not possible because of your being unconscious or for some other reasons, your nearest relatives must be told before they consent to the operation. There are multiple therapeutic options for some disorders. Unless there is a clear-cut advantage of one option over another, the patient should be given a choice of options. In fact the option used should be discussed and decided by the patient and the physician. A knowledgeable friend or relative may represent the patient, but someone from the patient’s side should always be involved in the decision making process. The physician should also consider the economic burden of a particular therapeutic modality on the patient’s family. The benefit of saving a life should be carefully balanced against the possible economic ruin of the family. The COER states: Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed.

- If patient is to be discharged or moved to another hospital, you have a right to be informed in advance and to make your own choice of hospital of nursing home, in consultation with the doctor. A hospital may be justified in shifting a patient to another hospital or nursing home if the patient will not benefit from treatment at the hospital, if the services necessary are not available, or if the patient cannot afford the fees (emergency treatment must be provided and the patient stabilized before such a shift). However, it is also believed that private hospitals sometimes shift seriously ill patients to a public hospital to avoid problems. However, this is not addressed in the COER.
Patient has a right to get your case papers upon request. Many instances have been reported of hospitals and clinics denying this right to patients and their families, possibly as a way of preventing the patient from seeking treatment elsewhere, or even getting a second opinion. The COER states as follows: If any request is made for medical records either by the patients / authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours. Despite the rights given in the charter, it is widely believed that patients’ rights in India are treated very lightly and are not honored in most medical establishments. Whether recognition is given to the patient’s rights or not depends upon a variety of factors. We have identified the following issues based on our own experiences as physicians and also as patients and patients’ relatives. The patient’s gender, age and education are decisive factors in the disclosure of information or choice for the patient. Female patients may be given less information, or choice about their treatment, though greater confidentiality may be maintained about them. If the patient is uneducated or not highly educated, the treatment meted out to them is pathetic. The authors’ experience suggests that even when highly qualified people are ill, they are often treated with total disregard to their qualifications and experience. Patients from the higher economic strata get better treatment and have a higher autonomy than the less privileged, but this is only to be expected since money plays a significant role in ensuring better services. Patients may have more autonomy in urban compared to rural areas. The attitude of the physician is a deciding factor in respect to patients’ rights. The higher the status and education of the physician, the less autonomy resides with the patient. There are highly qualified physicians who share all information with the patient, but they are in a minority. The disease suffered by the patient is a major factor that decides the autonomy of the patient; the poorer the prognosis, the less the autonomy. A physician might give all information to the patient if the diagnosis is one of appendicitis, but not if it is of pancreatic cancer. There have to be reasonable limitations on the autonomy of the patient, and not all patients can be given full autonomy. For example, a patient with psychiatric illness should not be given more autonomy, and it is not given. It is not clear what happens if the physician has a psychiatric illness. After all, physicians come from the same society as patients, and there is no periodic
assessment of physicians’ mental health. Internationally, there are many problems in mentally incompetent patients enjoying rights like any other patients. The United Nations Principles for the Protection of Persons with Mental Illness of 1991 has significant drawbacks and implementation is far from perfect. The COER states: Medical practitioner having any incapacity detrimental to the patient or which can affect his performance vis-à-vis the patient is not permitted to practice his profession. One wonders whether this clause of the code is, or can be, enforced in practice.\textsuperscript{46}

From the above discussion, it can be inferred that, the patients are valued as important consumers and their interests are protected by various rights stated above.

3.5 Relationship of the concept with Patient as Consumer and Medical Profession as Service Provider

Is the Relation between Medical Practitioner and patient- a contract for service?

It was urged in the instant case that the relationship between a medical practitioner and the patient is of trust and confidence and therefore it is in nature of a contract of personal service and the service rendered by the medical practitioner to the patient is not “service” under Section 2(1) (o) of the act. The contention ignores the well recognized distinction between a “contract of service” and “contract for service”. A “contract for service” implies a contact whereby one party undertakes to render services e.g. professional or technical services to or for another in the performance of which he is not subject to detailed direction or control but exercises professional or technical skill and used his own knowledge and discretion. A “contract of service” implies a relationship of master and servant and involves an obligation to obey orders in the work to be performed and as to its mode and performance. The court entertain no doubt that parliamentary draftsmen was aware of this well accepted distinction between “contract of service” and “contract for service” and has deliberately chosen the expression “contract of service” instead of expression “contract for service” in the exclusionary part of the definition of “service” in Section 2(1)(o). The reason is that an

\textsuperscript{46} Id.
employer cannot be regarded as a consumer in pursuance of a contract of employment.\textsuperscript{47}

By affixing the adjective “personal” to the word “service” the nature of the contracts which are excluded is not altered. The said adjective only emphasizes that what is sought to be excluded is personal service only. The expression “contract of personal service” in the exclusionary part of Section 2(1) (o) must therefore be construed as excluding the services rendered by an employee to his employer under the contract of personal service from the ambit the expression “service”.

It is true that the relationship between a medical practitioner and a patient carries within it certain degree of mutual confidence and trust and therefore the services rendered by the medical practitioners can be regarded as services of personal nature. But since there is no relationship of master and servant between the doctor and the patient the contract between medical practitioner and patient cannot be treated as contract of personal service but it is a contract for services and the service rendered by the medical practitioner to his patient under such a contract is not covered by the exclusionary part of the definition of “service” contained in Section 2(1) (o) of the Act.

Private Doctors services are also covered under the Act.\textsuperscript{48}

Adverting to the individual doctors employed and service in the hospitals, the Court was of the view that such doctors working in the hospital/nursing home/ dispensaries/whether Government or private belonging to categories (ii) and (iii) would be covered by the definition of “service” under the Act and as such are amenable to the provisions of the Act along with the management of the hospital, etc. jointly and severally.

There may be however, be a case where a person has taken an insurance policy for Medicare where under all the charges of consultation, diagnosis and medical treatment are borne by the Insurance Company. In such a case the person receiving the treatment is a beneficiary of the service which has been rendered to him by the medical practitioner cannot be said free of charge and would therefore fall within the

\textsuperscript{47} Law Teacher-Consumer Protection in India- www.lawteacher.net accessed on 27 June 2012

\textsuperscript{48} Id
ambit of the expression in Section2(1)(o) of the Act. So also there may be cases where as a part of the conditions of service the employer bears the expense of medical treatment of the employee and his family members' dependant on him. The service rendered to him by a medical practitioner would not be free of charge and would therefore constitute service under Section 2(1) (o).49

In Indian Medical Association v. V.P. Shantha and Ors50the principal issue which arose for decision before the Supreme Court was whether a medical practitioner renders 'service' and can be proceeded against for 'deficiency in service' before a forum under the Consumer Protection Act, 1986. The Court dealt with how a 'profession' differs from an 'occupation' especially in the context of performance of duties and hence the occurrence of negligence. The Court noticed that medical professionals do not enjoy any immunity from being sued in contract or tort (i.e. in civil jurisdiction) on the ground of negligence. However, in the observation made in the context of determining professional liability as distinguished from occupational liability, the Court has referred to authorities, in particular, Jackson & Powell and have so stated the principles, partly quoted from the authorities :-

"In the matter of professional liability professions differ from occupations for the reason that professions operate in spheres where success cannot be achieved in every case and very often success or failure depends upon factors beyond the professional man's control. In devising a rational approach to professional liability which must provide proper protection to the consumer while allowing for the factors mentioned above, the approach of the Courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services.

The Court held that even though services rendered by medical practitioners are of a personal nature they cannot be treated as contracts of personal service (which are excluded from the Consumer Protection Act). They are contracts for service, under

49 Supra note
50 1996 AIR 550
which a doctor too can be sued in Consumer Protection Courts.\textsuperscript{51}

\section*{3.6 Summary}

The efficient and effective programme of Consumer Protection is of special significance to everyone because everyone is a consumer. Even a manufacturer or provider of a service is a consumer of some other goods or services. If both the producers/ providers and consumers realize the need for co-existence, then, adulterated products, spurious goods and other deficiencies in services would become a thing of the past. The active involvement and participation from all quarters i.e. the central and state governments, the educational Institutions, the NGO’s, the print and electronic media and the adoption and observance of a voluntary code of conduct by the trade and industry and the citizen’s charter by the service providers is necessary to see that the consumers get their due. The need of the hour is for total commitment to the consumer cause and social responsiveness to consumer needs..\textsuperscript{52}

However, the relationship of patient as consumer is debatable as shown above.

There should be no basic quarrel holding that a patient harmed by the treatment rendered by a doctor or a hospital for a consideration can claim damages under the Consumer Protection Act, 1986. Punishment for medical negligence is made conditional on a number of parameters to serve the longer objective that medical practitioners should confirm to the code of medical ethics. It is also established that doctors and hospitals if fail to exercise reasonable skill and care in the treatment of patients entrusting themselves to their care, they are as much liable to pay the price of negligence as others.

\textsuperscript{51} Supra note 315

Therefore the efforts of the Consumer Protection Courts are to cleanse the medical profession and safeguard the consumer rights. But the major apprehension is that the very constitution of the Redressal.\textsuperscript{53}

Invariably, consumers are a vulnerable lot for exploitation, more so in a developing country with the prevalence of mass poverty and illiteracy. India too is no exception to it. Instances like overcharging, black marketing, adulteration, profiteering, lack of proper services in trains, telecommunication, water supply, airlines, etc are not uncommon here. From time to time, the government has attempted to safeguard consumer’s interests through legislations and the CPA 1986 is considered as the most progressive statute for consumer protection. Procedural simplicity and speedy and inexpensive redressal of consumer grievances as contained in the CPA are really unique and have few parallels in the world. Implementation of the Act reveals that interests of consumers are better protected than ever before. However, consumer awareness through consumer education and actions by the government, consumer activists, and associations are needed the most to make consumer protection movement a success in the country.\textsuperscript{54}

Exploring the impact of such approach and conceptual framework in case of medical negligence, the following chapter presents the data and analysis extracted from the doctrinal study, case law analysis based on variables.

\textsuperscript{53} Raghunath Pramanik, Medical Service and Consumer Protection, 52 Central India Law Quarterly. Vol.9.1
\textsuperscript{54} Gomathi Vishwanathan, : \url{http://EzineArticles.com/?expert=Dr._Gomathi_Vishwanathan}