Chapter VI
Conclusion
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It is clearly established that in India, Consumer Protection Act, 1986 gives the best remedy available for deficiency in medical service generally and specifically in surgical care. But the dispute is on how far or how limited is the access of this legislation. And how expeditious this remedy is actually reaching the people to whom it intended to reach.

COPRA, 1986 was passed with high hopes. India was the first country to enact legislation, immediately after the United Nations came up with the model. The apparent objectives of the Act include providing the right to get consumer education. This statute has shouldered central/state governments, responsibility to set up Consumer Protection Council, which will work towards achieving the declared objectives. It establishes a three tyre system of Redressal Agencies which will provide economic, expeditious and effective remedy with a rather informal approach.

Ever since Indian medical Association case\textsuperscript{933} settled that ‘medical service ‘is ‘service’ under COPRA, The Consumer Courts are being depicted as the solace for a party injured by the negligence of a doctor. Number of medical litigations is increasing. More issues are gaining significance on medical mal-practice including vitiated consent, defensive medicine, product liability, compensation etc. But the most critical question is, ‘does the current system of consumer protection is equipped enough to fight against deficiency in medical services? This study has mainly focused on analysing the data on, law and practice of Medical negligence and Consumer Protection in India, other legislation in the health sector, legal position in other countries-mainly US and UK and some Common Law jurisdictions, judge made laws in India as well as abroad, data collected by earlier researchers etc. In the process the following observations were made.

While Consumer Protection legislation is a driving force for compliance of quality standards for manufacturers, retailers and service providers, there is a

\textsuperscript{933} IMA supra note 527
vast difference in their influence across region and across services. Informed citizenry is the prime mover of implementation of any law, the absence of which will slacken such a movement. In India—in any part of the world for that matter—a patient is a delicate human being. He is down not only physically but there is a set back at mental and emotional level also. This is the critical concern one should have before looking into medical malpractice liability. Considering the social, financial and economic status of a medical practitioner, the patient is vulnerable—irrespective of his economic status. Therefore, the arithmetic allocation—the reversal of wrongful changes to an initial distribution of resources—will not give fair result. The glaring facts about medical practitioner’s civil liability in India are follows.

- COPRA, 1986 gives easy and economic accessibility to judicial forums and expeditious remedy.
- The current legal position establishes that ‘medical service’ is ‘service’ under COPRA.
- Consumer Fora established under the Act are capable to decide matters relating to Deficiency in Medical Service.
- Generally, like in any other civil suit, the burden of proof is with the complainant.
- Principles of Tort Law such as, *res ipsa loquitur*, vicarious liability, are applicable in such cases.
- Unless it is necessary, expert evidence is not the rule.
- The doctor is not negligent; if he follows methods which are accepted by professional body of medical men. But reasonability is always subject to judicial review.
- Medical interference without consent is considered to be deficiency in service. However, disclosure of information can be subjective to the physician’s point of view.
- COPRA, 1986 is the best available remedy for Deficient Medical Services

Studies suggest that, awareness among Indian population about the Consumer rights is remarkably low. It is true that information only will not emancipate the
injured party to move to court and demand justice. There are other factors such as accessibility and satisfactory functioning of the adjudicatory mechanism, absence of delay, finality of decisions and certainty of relief. But information about the available rights is a pre-requisite.

As per the National Health Profile 2015 published by the Ministry of Health and Family affairs, in India 25.96% of the population is illiterate. According to the estimate 25.7% of rural and 13.7% of urban population live below poverty line. The report says that there is a persistent inequality in health status between and within states due to various economic and social causes. The share of centre in total public expenditure on health is declining steadily over the years. The public spending on health in India, as a percentage of GDP, is one of the lowest among South-East Asian countries and the lowest among Brazil, Russia, India and China (BRIC nations).

In India, majority of citizens requiring medical care and treatment fall below the poverty line. Most of them are illiterate or semi-literate. They cannot comprehend medical terms, concepts, and treatment procedures. They cannot understand the functions of various organs or the effect of removal of such organs. They do not have access to effective but costly diagnostic procedures. Poor patients lying in the corridors of hospitals after admission for want of beds or patients waiting for days on the roadside for an admission or a mere examination is a common sight. For them, any treatment with reference to rough and ready diagnosis based on their outward symptoms and doctor's experience or intuition is acceptable and welcome so long as it is free or cheap; and whatever the doctor decides as being in their interest, is usually unquestioningly accepted. They are a passive, ignorant and uninvolved in treatment procedures. The poor and needy face a hostile medical environment - inadequacy in the number of hospitals and beds, non-availability of adequate treatment facilities, utter lack of qualitative treatment, corruption, callousness and apathy. Many poor patients with serious ailments (e.g. heart patients and cancer patients) have to wait for months for their turn even for diagnosis, and due to limited treatment facilities, many die even before their turn comes for treatment. What choice do these poor patients have? Any treatment of whatever degree is a boon or a favour, for them. The stark reality is that for a vast majority in the country, the concepts of informed consent or any form of consent, and choice in treatment, have no meaning or relevance.

934 National Health Profile-2015 supra note 501
935 Id
This is the reflection of Indian Supreme Court in 2008.\textsuperscript{936} Situation has not changed much even after 8 years.

There is new-generation medical consumer emerging. Since they are tech and net savvy, information is readily available for them. But the dependability on the doctor or the hegemony of his fellow men never diminishes. The doctor may no longer be considered as ‘God’ but his relationship with the patient is still fiduciary.

Remarkable developments in the field of medicine might have revolutionized health care. But they cannot be afforded by the common man. The woes of non-affording patients have in no way decreased. Gone are the days when any patient could go to a neighbourhood general practitioner or a family doctor and get affordable treatment at a very reasonable cost, with affection, care and concern. Their noble tribe is dwindling. Every Doctor wants to be a specialist. The proliferation of specialists and super specialists, have exhausted many a patient both financially and physically, by having to move from doctor to doctor, in search of the appropriate specialist who can identify the problem and provide treatment. What used to be competent treatment by one General Practitioner has now become multi-pronged treatment by several specialists.\textsuperscript{937}

In medical malpractice cases, the consumer is in a more delicate situation were in the material evidence which he need to produce for proving the case, is many times in the custody of the doctor or the hospital. He needs to rely on the legal system to obtain them in order to even initiate a legal action. In case of surgery, it involves use of such intricate technology, specialist skills and thorough technical knowledge. It becomes impossible for a layman to determine, ‘who is at fault?’ These are some of the many problems which an average medical litigant is facing in practical life. There are many more critical hurdles, very much part of the system which he needs to overcome in winning a legal battle.

There is a general perception among the middle class public that these private hospitals and doctors prescribe avoidable costly diagnostic procedures and medicines, and subject them to unwanted surgical procedures, for financial gain. The public feel that many doctors who have spent a crore or more for becoming a specialist, or nursing homes which have invested several crores on diagnostic and infrastructure facilities, would necessarily operate with a purely commercial and not service motive; that such doctors and hospitals would advise extensive

\textsuperscript{936} Sameera Kohli, supra note 936
\textsuperscript{937} Id
costly treatment procedures and surgeries, where conservative or simple
treatment may meet the need; and that what used to be a noble service
oriented profession is slowly but steadily converting into purely a
business.\textsuperscript{938}

This study has focused on Deficiency in Surgical Treatment and it revealed the
following facts:

- Medical Negligence is Deficiency in Service. However Deficiency in
Medical Service is a wider connotation, which includes actions, not
necessarily negligent.
- Surgery is a form of medical interference which requires specialist skills.
- The surgeon is not expected to cure, but to exercise the reasonable diligence
and high standard of knowledge which he professes.
- Indian Courts and Consumer Fora have accepted that any kind of surgery
involves risk.
- Lack of preparation before performing surgery is held to be deficiency in
service.
- Not conducting proper diagnosis is negligence, but practice of defensive
medicine will also amount to deficiency.
- Duty of surgeon extends to post-operative care. Therefore discharging the
patient without clear instructions for continued care will amount to
negligence.
- Abandoning a patient after surgery is deficiency in service.
- The Courts in India follow the methods of law of Tort in assessing and
awarding compensation.
- Indian Courts still follow Bolam principle for fixing medical negligence
liability, a principle which has been watered down, if not abandoned by
\textit{Bolitho},\textsuperscript{939} \textit{Chester}\textsuperscript{940} and \textit{Montgomery}\textsuperscript{941} decisions in its birth place.
- Informed consent from the patient’s perspective is still not the law in India

\textsuperscript{938} Sameera Kohli supra note 936
\textsuperscript{939} supra note 91
\textsuperscript{940} supra note 455
\textsuperscript{941} supra note 460
There are no clear standards set in COPRA regarding the quantum of compensation. In each case the amount is determined by taking into various aspects, which need not be uniform or constant.

Consumer Redressal agencies, envisaged as speedier and effective alternative to Civil Courts have become another form of the latter with the unavoidable formal approach.

In these adjudicatory bodies which is conceived as informal agencies for informal one to one interaction, ubiquitous presence of advocates is noticed.

The time limit of 60-120 days for passing an order is hardly observed.

There is a frustrating delay in adjudication before these Fora.

The well-intended appeal provisions are used by mighty defendant to swindle the system and stag the matter.

There is lack of enthusiasm on the part of the state governments in setting up and functioning of Consumer Protection Councils

The Adjudicatory bodies are poorly manned and inadequately equipped.

Major attempts are required to create awareness among the population about Consumer Rights.

Establishment and working of Consumer Fora is influenced by the Human right atmosphere-social, economic, educational disparities-. Lack of awareness about the Consumer Rights is major hurdle in implementation of this magnificent piece of legislation.

The large majority of Indian Population still has no accessibility to the protection of COPRA, 1986 since the medical services provided by Government hospital are out of the purview of Consumer Protection Act, 1986

In order to invigorate the consumer protection in India, the following changes are suggested. They are divided into two. Part A and Part B.

Part A consist of general suggestion. The Thesis is having a specific suggestion to enact new law and establish a new set of adjudicatory mechanism which will be free from the infirmities of COPRA. Part B contains the draft legislation.
Part A. General Suggestions

- The concept medical negligence has gone long way from Bolam principle. Changes are required in the legal provisions to define this civil wrong more clearly, as per the changing times.
- The principle of ‘real consent’ is no longer acceptable even in England. It is high time we moved towards the Canterbury principle of informed consent.
- The right to choose is a far cry as far as medical consumer is concerned. State funding as well as private investment has to be encouraged in this sector so as to have competition regime in operation.
- Since awareness is a major pre-requisite for empowerment of consumers, serious attempts are necessary in this direction. Consumer protection Councils must be invigorated in this direction.
- The right to consumer education needs to be materialised through effective and transparent channels.
- There is a need for clear guidelines on calculation of damages in case of Deficient Medical Service.
- Courts in India, maintain the stand that purpose COPRA is to compensate. But in specific cases like deficient medical services, vindication of patient’s right is very important. Since the victim’s socio-economic background is known to the wrong doer unlike other kind of negligence, remedy should not be only compensatory, it must be punitive too.

Part B. Salient features and Draft of the model legislation

The following are the salient features of the legislation.

- The Protection from Deficiency in Medical Services Act will be in the model of COPRA
- The objective of the Act will be to provide speedy and economic remedy for Deficiency in Medical Service to all citizen and to establish health tribunals for that purpose.
- The term ‘patient’ and ‘injured party’ will be defined instead of ‘consumer’ and ‘complainant’.
• It will establish ‘Health Tribunals’ in place of Consumer Redressal Agencies.
• The jurisdiction will be territorial and based on the number of population in the respective area.
• Appellate Tribunals will not have original jurisdiction.
• In general, Health Appellate Tribunal shall be the final court of appeal.
• Appeal to National Appellate Tribunal is subject to the leave of the Tribunal. Appeal is limited to only those cases having substantial question of law. This is to control the unnecessary appeals and unending delay.
• A responsibility will be cast on the state/central government to establish this tribunal and recruit its personnel, which will be right in the hands of citizen. There will be regular check on the functioning for which the respective governments shall be responsible.
• Specific provisions are incorporated to fix the compensation for Deficiency in Medical Service. Apart from the damages which will be calculated on the basis of well-established principles, a particular percentage of the income of the practitioner/hospital will be mandatorily paid to the victim in case of any proven deficiency.
THE PROTECTION FROM DEFICIENCY IN MEDICAL SERVICES ACT,
2016

[An Act to provide for better protection of the interests of patients from medical
negligence and for that purpose to make provision for the establishment of
adjudicatory authorities for the settlement of disputes and for matters connected
therewith.]

Whereas it is expedient to regulate deficiency in medical services provided in
the country both in public and private sector.

And whereas Parliament has no power to legislate for the states in the above
mentioned area except as provided in Article 249 and 250 of the Constitution.

And whereas in pursuance of clause (1) of Article 252 of the Constitution,
resolutions have been passed in the legislatures of the states to the effect that
matters aforesaid should be regulated by Parliament by law.

BE it enacted by Parliament in the Sixty-seventh Year of the Republic of India
as follows:—

CHAPTER I

Preliminary

1. Short title, extent, commencement and application.—

1) This Act may be called the Protection From Deficiency in Medical
   Services Act, 2016
   a. It extends to the whole of India except the State of Jammu and
      Kashmir.
   b. It shall come into force on such date as the Central Government
      may, by notification, appoint and different dates may be appointed
      for different States and for different provisions of this Act.
   c. Save as otherwise expressly provided by the Central Government
      by notification, this Act shall apply to all medical services.
2. Definitions.—

(1) In this Act, unless the context otherwise requires,—

a. Patient means; any person availing medical services under any law existing in India.

b. Medical Service means; Services of any description made available to a patient through a Registered Health Care Provider or a hospital, nursing home, clinic or health centre (Private or public) or any other place within the purview of ‘clinical establishment’ under the Clinical Establishments Act, 2010 or health camp organized with due permission from the authorities (by government or Private bodies) and includes services provided by Physiotherapist and a practitioner of alternate medicine.

c. Registered Health Care provider means;

i. a person having qualifications prescribed by the Indian Medical Council Act, 1956 and whose name is registered in the register under the Act

ii. any practitioner of Ayurveda, Unani, Siddha or any other as defined in Indian Medicine Central Council Act, 1970 and whose name is entered in the State Register or Central Register of Indian Medicine

iii. any person who is recognized under Homeopathic Central Council Act, 1973 and having his name registered in the central or state register

iv. any nurse or midwife having recognized under Indian Nursing Council Act, 1947 and having their name registered in the Indian Nursing Register or State Register

v. Any Recognized Dentist under Indian Dentist’s Act, 1948 and having his name registered in the central or state register

d. Deficiency in Medical Service means; means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance including absence of informed consent,
which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed in relation to any medical service.

Whereas informed consent under this provision would mean consent obtained by furnishing the kind of information which a reasonable patient or his dear and near, in similar circumstance would require to be able to take a balance decision.

e. Grievance means; any allegation in writing made by a patient that the medical services availed by him suffer from deficiency in any respect

f. Injured party means— a patient; or

(ii) any voluntary association registered under any other law for the time being in force; or

(iii) the Central Government or any State Government,

(iv) one or more patients, where there are numerous patients having the same interest;

(v) in case of death of a patient, his legal heir or representative;

g. Health Tribunal means; adjudicatory bodies established under this Act.

h. Terms such as, ‘persons having judicial background’, ‘prescribed’, ‘member’, ‘person’ ‘notification’ shall have the same meaning as that in Consumer Protection Act, 1986

CHAPTER II

Health Tribunals

3. Establishment of Health Tribunals: There shall be established for the purposes of this Act, the following Tribunals, namely:— (a) a Grievance Redressal Forum to be known as the "Health Tribunal" established by the State Government for areas having a population of not more than 20 lac of the State by notification:
4. Composition of the Health Tribunal.—(1) Each Health Tribunal is a quasi-judicial body and shall consist of,—

(a) a person who is, or has been, or is qualified to be a District Judge, who shall be its President;

(b) two other members, one of whom shall be a woman, who shall have the following qualifications, namely:—

(i) be not less than thirty-five years of age

(ii) be persons of ability, integrity and standing, and have adequate knowledge and experience of at least ten years in dealing with problems related to health and health care

(c) At least one member among them must possess a qualified medical degree from a recognised university

Provided that a person shall be disqualified for appointment as a member if he possesses any disqualification to be appointed as members of Consumer Redressal Agencies under COPRA, 1986

4. Jurisdiction of the Health Tribunal.—(1) Subject to the other provisions of this Act, the Health Tribunal shall have jurisdiction to entertain Grievance in the respective area. A Grievance shall be instituted in a Health Tribunal within the local limits of whose jurisdiction,—

(a) the opposite party or each of the opposite parties, where there are more than one, at the time of the institution of the complaint, actually and voluntarily resides or provides medical services

(b) any of the opposite parties, where there are more than one, at the time of the institution of the grievance, actually and voluntarily resides, or provides medical service

(c) the cause of action, wholly or in part, arises.
5. Appeal.—any person aggrieved by an order made by the Health Tribunal may prefer an appeal against such order to the Health Appellate Tribunal within a period of thirty days from the date of the order, in such form and manner as may be prescribed:

Provided that the Appellate Tribunal may entertain an appeal after the expiry of the said period of thirty days if it is satisfied that there was sufficient cause for not finding it within that period.

6. Composition of the Health Appellate Tribunal—(1) Each Health Appellate Tribunal shall consist of—

(a) a person who is or has been a Judge of a High Court, appointed by the State Government, who shall be its President:

(b) not less than two, and not more than such number of members, as may be prescribed, and one of whom shall be a woman, who shall have the following qualifications, namely:—

(i) be not less than thirty-five years of age;

(ii) be persons of ability, integrity and standing, and proven records in dealing with social issues and have adequate knowledge and experience of at least ten years in dealing with problems related health and health care

(c) A least one among them possess a qualified medical degree from a recognised university.

Provided that a person shall be disqualified for appointment as a member if he possesses any disqualification to be appointed as members of Consumer Redressal Agencies under COPRA, 1986

Provided that not more than fifty per cent of the members shall be from amongst persons having a judicial background.

7. Jurisdiction of Health Appellate Tribunal—(1) Subject to the other provisions of this Act, the Health Appellate Tribunal shall have jurisdiction—:
(a) to entertain appeals against the orders of any Health Tribunal within the State; and

(b) to call for the records and pass appropriate orders in any consumer dispute which is pending before or has been decided by any Health Tribunal within the State, where it appears to the Health Appellate Tribunal that Health Tribunal has exercised a jurisdiction not vested in it by law, or has failed to exercise a jurisdiction so vested or has acted in exercise of its jurisdiction illegally or with material irregularity.

8. Appeal — Any person aggrieved by an order which involves substantial question of law, made by the Health Appellate Tribunal in exercise of its powers may prefer an appeal against such order to the National Health Appellate Tribunal within a period of thirty days from the date of the order in such form and manner as may be prescribed:

Provided that the National Appellate Tribunal may entertain an appeal after the expiry of the said period of thirty days if it is satisfied that there was sufficient cause for not filing it within that period. Whereas appeal to the National Health Tribunal shall be subject to the leave of the Tribunal. After a preliminary hearing the Tribunal may reject to entertain appeal if it finds the matter contains no substantial question of law.

9. Jurisdiction of National Health Appellate Tribunal— Subject to the other provisions of this Act, the National Health Appellate Tribunal shall have jurisdiction— (a) to entertain appeals against the orders of any Health Appellate Tribunal involving substantial question of law and

(b) to call for the records and pass appropriate orders in any consumer dispute which is pending before or has been decided by any Appellate Health Tribunal where it appears to the National Health Appellate Tribunal that Health Appellate Tribunal has exercised a jurisdiction not vested in it by law, or has failed to exercise a jurisdiction so vested or has acted in exercise of its jurisdiction illegally or with material irregularity.
10. Composition of National Health Appellate Tribunal.

(1) National Health Appellate Tribunal shall consist of—

(a) a person who is or has been a Judge of the Supreme Court, appointed by the Central Government, who shall be its President and such number of judicial members decided by the Central Government.

Provided that a person shall be disqualified for appointment as a member if he possesses any disqualification to be appointed as members of Consumer Redressal Agencies under COPRA, 1986.

11. Every appointment shall be made by the Central/State Government on the recommendation of a selection committee consisting of the following, namely:—

(i) The Chief Justice of the Supreme Court/State High Court—Chairman.

(ii) Secretary, Law Department of the Union/State—Member.

(iii) Secretary of the Department of Health and Family welfare in the Union/State—Member.

(IV) Representatives from Health Right Activists

(V) Representatives from Active Consumer Organizations.

12. Appeal.—Any person, aggrieved by an order made by the National Commission in exercise of its powers conferred by sub-clause (i) of clause (a) of Section 21, may prefer an appeal against such order of the Supreme Court within a period of thirty days from the date of the order:

Provided that the Supreme Court may entertain an appeal after the expiry of the said period of thirty days if it is satisfied that there was sufficient cause for not filing it within that period.

13. Tenure, salary and other perks of the members of Tribunal shall be prescribed by the appropriate governments from time to time.
14. Procedure before the tribunals, manner of filing grievance, rules regarding expediency finality of orders, administrative control by the Appellate Tribunals, power to remove difficulties and protection for action taken under good faith shall be as prescribed under Consumer Protection Act, 1986.

15 A duty shall be cast on the Health Tribunals for creating awareness regarding the rights of patients within their respective population. For this purpose, the State Government shall sponsor and facilitate by:

i. Conducting seminar, holding lectures to specified group of population and organizing competitions among students

ii. Using electronic and other media

16. Notwithstanding anything contains in any legislation, a registered health care provider shall be liable to pay a particular percentage of his annual income in any case of proven case of deficiency in medical care to the injured party.

Scope for Further Study

This study is focusing on civil liability for deficiency in medical service under Consumer Protection Act; 1986 with an emphasis on surgical treatment. Enumerable further studies can be originated as an offshoot of this analysis. The following are some of them.

- Though the general tendency in India is to consider Medical Negligence as a civil wrong, criminal cases are also filed and doctors are prosecuted in gross medical negligence cases. An analytical study on criminal liability – situations in which it is attracted, legal position, extent- for Medical Negligence will enrich the respective legal spectrum. This will be particularly informative when a comparative analysis of both these branches of law and their effect on prevention is made in Indian context.

- COPRA is not applicable to services rendered free of charge in Government hospitals, leaving large majority of poor patients availing public health care, outside its purview. The remedy available to them is to approach High
Courts through a writ petition. Therefore constitutional liability for Medical Negligence gathers significance.

- As a part of studying Medical Negligence liability, a separate analysis in done with respect to law relating to medical consent in India. Studies more focused on medical consent of mentally challenged patients, ethics and legal aspects of therapeutic privilege etc. are relevant and requires deeper study.
- Civil liability for deficiency in service during clinical trials is an emerging topic and a subject of serious attention.