CHAPTER-IX
CONCLUSION AND SUGGESTIONS

Rapid development in science and technology has made remarkable contribution to the modern society. But at the same time, the progress of civilization has increased the complexities of human activities. Medical science has done a tremendous service to the human kind in numerous ways. The medical professional’s cardinal aims are to preserve life, prevent disease and to effect the cure of illness. But success or failure of a system depends on the people who handle it. Hence medical men, running the profession or an institution are the pivots who make it successful.

Health care, (like education) can thrive in the hands of charitable institutions. Moreover it also requires more serious attention from the State. In a developing country like ours, where teeming millions of poor, downtrodden and illiterate cry out for health care, there is a desperate need for making health care easily accessible and affordable. Remarkable developments in the field of medicine might have revolutionalised health care, but they cannot be afforded by the common man. The woes of the economically disadvantaged patients have in no way decreased. Gone are the days when any patient could go to a neighbourhood general practitioner or family doctors and get affordable treatment at a very reasonable cost, with affection, care and concern.¹ Such a noble tribe is slowly dwindling. Every doctor wants to be specialist. The proliferation of specialists and super specialists, have exhausted many 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 adequate treatment. What used to be competent treatment by one general practitioner has now become multi-pronged treatment by several specialists.

¹ The Alma Ata Declaration adopted by WHO in 1977/78 issued a challenge of “Health for all by 2000” AD. India, a signatory, is far from that dream. Medical facilities, in the public sector need over-hauling as the poor rural folk are largely dependent on it. As in the New York patient’s charter doctors should be made to attend medical school for at least 50 days every year to make themselves trained in the latest breakthrough in medical sciences. However the umbilical cord of trust between patients and the doctor must not snap. The nobility of the medical profession should not be compromised. Charak’s oath of initiation seems to an order for today’s doctors.
Apart from taking every care in high risk situations which are common causes for medical negligence actions, the medical practitioner are expected to safeguard their position, career and financial aspect through risk insurance. This kind of liability risk is the professional hazard for medical personnel while the risk of the ordinary person is life, health, expenditure, agony, loss of future earning etc. It is clear that both the patient and the doctor are under a risk of either physical injury in the shape of spoiled health, or sudden burden to pay compensation under direction of Consumer forum. Even if the issue of rights and liabilities are left to the decision of the courts, which may take a long time, there is an urgent practical necessity for patient to recover and doctor to be in position to pay. The only remedy available is the insurance. The professional indemnity insurance provides insurance cover in respect of error and omissions on the part of the professionals while rendering their services.

As a consequence, it is now common that a comparatively simple ailment, which earlier used to be treated at the cost of a few rupees by consulting a single doctor, requires an expense of several hundreds or thousands on account of four factors: (i) commercialization of medical treatment: (ii) increase in specialists as contrasted from general practitioners and the need for consulting more than one doctor: (iii) varied diagnostic and treatment procedures at high cost and (iv) need for doctors to have insurance cover. The answer to such variety of problems would be an increased participation in health care by the State and charitable institutions. An enlightened and committed medical profession can also provide a better alternative. The researcher is only worried about the enormous hardship and expense to which the common man is subjected, and is merely voicing the concern of those who are not able to fend for themselves.

In private practice, where the relationship of doctors and patients are contractual in origin, the services are in consideration of a fee paid by the patient, where the contract implies that the professional men possessing a minimum degree of competence would exercise reasonable care in the discharge of their duties while giving advice or treatment
The position of doctors in government and charitable hospitals is not better. They are overworked, understaffed, with little or no diagnostic or surgical facilities and limited choice of medicines and treatment procedures. They have to improvise with non-existent facilities and limited dubious medicines. They are required to be committed, service oriented and non-commercial in outlook. What choice of treatment can these doctors give to the poor patients? What informed consent can they take from them? One may say that they are trying to do their best in such limited circumstances.

But unfortunately not all doctors in government hospitals are paragons of service, nor fortunately, all private hospitals/ doctors are commercial minded. There are many doctors in government hospitals who do not care about patients and unscrupulously insist upon “unofficial” payment for free treatment or insist upon private consultation. On the other hand, many private hospitals and doctors give the best treatment without exploitation, at a reasonable cost, charging a fee, which is reasonable recompense for the service rendered. Of course, some doctors, both in private practice or in government services, look at patients not as persons who should be relieved from pain and sufferings by prompt and proper treatment at an affordable cost, but as potential income- providers/ customers who can be exploited by prolonged and radical diagnostic and treatment procedures. It is this minority who bring a bad name to the entire profession.

In India, the Health Minister commissioned a study of 81 hospitals covering Delhi, Hyderabad and Lucknow. The field surveys of the same were conducted by a consumer association of Delhi –VOICE. 2 Another NGO (Antim Nagrik) working in the field of Human rights and Consumer Rights in the suburb’s of U.P., after conducting a study in District Government Hospitals concluded that hospitals are the worst violators of human rights. 3

---

The study brought out that doctors and the rest of the medical staff were not just callous towards patients but careless in performing their duties. Moreover most hospitals did not even provide mechanisms for registering complaints. It is unfortunate that even after the Pondicherry Declaration exposed these very loopholes in 1993, nothing was done.\textsuperscript{4}

The Central Government has now begun work on a comprehensive regulatory policy for private hospitals and nursing homes across the country. It will also look into ways and means of standardizing the amount of fees charged by private hospitals and private clinics. Explaining the importance of such a policy, the Minister pointed out that “There is an urgent need to put them in leash, otherwise life saving institutions will become like life taking centers.”\textsuperscript{5} There is no specific legislation dealing with such factors in India.

In India, the situation is altogether different from the more advanced legal systems. Every day one may come across new kinds of negligence on the part of medical authorities. There are reported instances where some quacks operating for cataract removed sound eyes of many people, doctors gave penicillin injection without testing, causing the death of patients and there are many more countless cases. It is also shocking to discover that not all cases reach the courts. Lack of legal literacy, economic backwardness of the general public, problem of evidence to prove medical negligence, expensive and dilatory court system are the reasons responsible for slow development of law of medical negligence in India. Malpractice in medical system is increasing gradually, tolling the alarm bells and drawing the attention of the concerned people for evolving a system conducive to the suffering people.

Absence of competent court system, delay in processing the case, compliance of faulty procedure and absence of patient centered approaches are the main drawback of existing system. Thus the system has now become passive and meaningless. Several

\textsuperscript{4} Ibid.
\textsuperscript{5} Ibid.
instances of negligence are reported from government hospitals. But unfortunately the consumer law is silent here as it comes under the “non-paid” service. Hence there is a need for an extensive change. The researcher is putting forward several recommendations which could be integrated into legislation.

Suggestions

Following are the main suggestions to reform the present system. The following recommendation should be incorporated within the frame work of new proposed legislation

1. Recommendation For a new Legislation

In India, Medical Negligence jurisprudence does not have any statutory guidelines. So the doctrines like “Accepted Practice”, “Informed consent”, “Ship- Captain Theory” were developed by the Court in the absence of any Law. These doctrines must be integrated within the provisions of a new law.

Medical Malpractice Claims Act is the need of time. It was aptly stated by Tindal.C.J., in Hancke v. Hooper 6 “A surgeon does not become an actual insurer, he is only bound to display sufficient skill and knowledge in his profession. If for some accident, or some variation in frame of a particular individual injury happens, it is not the fault of the medical man. Hence an expert law and an expert court are necessary to deal with this issue.” So an effective law in tune with the changes in medical science is mandatory.

In USA, Maryland legislature adopted the Health Care Malpractice Claims Statute in 1976. This statute requires that medical malpractice litigants must attempt to resolve their disputes by submitting them to an arbitration panel before resorting to court action. 7

---

6 (1835)76 U S R , p.8
7 Kevin. G.Quinn, The Health Care Malpractice Claim Statute- Maryland response to the Medical Malpractice Crisis, University of Baltimore Law Review, 1990, Vol.10, p. 73
“In the United States legislative measures have been adopted by various States as to ceiling of damages, shortened statute of limitation, mandatory screening of malpractice claim, and the voluntary (but if chosen: binding) arbitration. Screening and arbitration have become increasingly popular alternatives to medical malpractices litigation, aimed at reducing delays, cutting legal expenditures and diminishing the price of malpractice insurance”.  

2. Medical Malpractice Tribunal System

The functioning of the consumer tribunal has not been commendable. This fact was admitted by the Supreme Court itself in the case of Dr. J.J. Merchant v. Srinath Chathurvedi. This PIL questioned the functioning of the consumer courts and the Supreme Court commended that, “after enactment of the Act, appropriate steps have not been taken by the Government for ensuring that the National Commission or the State Forums can function properly. Also the Consumer Dispute Redressal Agencies have not been fast enough in disposing cases. Several bottle-necks and shortcomings have also come to light in the implementation of the various provision of the Act”.

Another comment of Supreme Court in Indian Medical Association v. V.P. Shantha is that “Consumer Dispute Redressal Agencies are not required to have knowledge and experience in medicine that they do not have to deal with issue.”

So it is suggested that a separate court system should be established to adjudicate these cases. Separate Medical Malpractice tribunal should be established in specified regions covering many districts. Each tribunal should be headed by Medical Legal experts, so that no aspect of litigation is left unconsidered. Judges of these tribunals should be essentially equipped with the knowledge of medicine also. If not they may

---

9 (2002) 6 SCC 635: AIR 2002 SC 2931
10 Ibid, Para, 2
have to rely on testimony of medical experts, which is subject to prejudices and bias for their colleagues besides being a time consuming process. “In the absence of expert medical testimony to show negligence on the part of the physician, the suit should be dismissed when the doctrine of res-ipsa loquitur does not apply, likewise, the suit should be dismissed if there is no sufficient evidence to permit a finding that the patient’s injury was proximately caused by the physician’s negligence. To be sufficient, the evidence must be more than conjectural or speculative.”¹²

Appeal from these tribunals should lie to the appellate tribunal for medical Malpractice situated at the seat of High Court of respective state. These appellate tribunals should be presided over by the Judges of inter disciplinary (Medico-legal) expertise and they should have status, salary and benefits equal to High Court Judges.

Appeal from these tribunals should lie to the Supreme Court. There should be a separate division in the Supreme Court dealing with such cases and constituted by the judges having Medico- Legal knowledge. Powers and functions should be as in the case of consumer Forums and Commissions.

In federal republic of Germany, Arbitration Boards have been set up on experimental basis. “The purpose of these boards of arbitrators is to try and end the dispute and perhaps to compensate the damage without recourse to the ordinary courts which, however, are always open for both parties at any time of the declarations.” Cases of alleged medical negligence are referred to these boards with the agreement of all parties. The boards normally consists of two representatives of the States branch of Federal Medical Association, one of whom must be a specialist in the field under discussion and a representative of doctor and another of the patient and a lawyer. ¹³

¹³ *Ibid* at p. 190.
Medical Ombudsman system has been constituted in U.K. also for the speedy disposal of cases relating to complaints about National Health Service in England.

It is hoped that above suggested system will be able to provide relief to the masses who are subjected to maltreatment but remain unaddressed. Court fee should also be done away within medical negligence cases, so that even the lowest strata of society may get justice against medical malpractices.

2(a) Regarding Constitution and Composition of Medical Tribunal System

There shall be a District Medical Malpractice Tribunal System at the District Level, State Medical Malpractice Tribunal System at the State level and National Medical Malpractice Tribunal System at the National level. District Malpractice Tribunal System shall consist of two members. One shall be selected from the judicial officer having the rank of District Judge, who shall be its president. The other person should be a Senior Professor of Medical Science from the Reputed Medical College relating to that particular state. The State Medical Malpractice Tribunal System shall consist of two members. One shall be selected from judicial officer having the rank of the High Court Judge, who shall be its president. The other person shall be selected from the Senior Professor of Medical science from the reputed Medical College. The National Medical Malpractice Tribunal shall have two members. A person, who is the judge of Supreme Court, shall be the president. The judge shall be appointed by the Central Government after consultation with the Chief Justice of India. Other member should be a Senior Professor of Medical Science from the All India Institute of Medical Science.

---

14 The Health Service Ombudsman constituted in UK as an ADR system. They investigate complaints about the National Health Service (NHS) in England. The Health Service Ombudsman covers NHS hospital, trust and health authorities, Gps, dentists, opticians, pharmacist and other providers. The part of parliamentary and Health Service Ombudsman are attached to the Westminster Parliament, with additional post at the Scottish parliament, the Welsh Assembly and other government institution.
The selection process of these judges and doctors should be according to the nomination by a selection committee. As far as the District and State Medical Malpractice Tribunal System is concerned the selection committee should be constituted by the Chief Justice of the concerned State, Secretary in charge of department of legal affairs and Secretary in charge of department of health of the concerned State. The selection committee has the power to nominate members. National Selection committee should be constituted under the Chairman ship of Chief justice of India, Secretary in charge of department of legal affairs in the Government of India and secretary in charge of department of health Government of India. The judges shall be trained in Medico-legal aspect. This is necessary for the objective appreciation of evidence submitted in court.

2(b). For Filing Appeal

Any person aggrieved by any order made by the District Medical Malpractice Tribunal may prefer an appeal to the State Malpractice Tribunal within a period of 30 days. An appeal filed before the State Tribunal or the National Tribunal shall be heard within a period of 90 days. Also a provision can be made for an appeal from the National Tribunal to Supreme Court within a period of 30 days from the date of order, so that speedy disposal of Medical Dispute is effected through this system.

The time taken by the Consumer Court in deciding the complaints and appeals was found to be quite long. In certain cases, the National commission took as long as four years. In the initial years of functioning, there was no case left pending for disposal with the National commission and various State Commissions. However, from the year 1992, the number of cases pending for disposal has increased at a very fast rate so much so that more than 40% cases were pending till March 31st 2007, before the National commission and various state Commissions. The position of the Delhi State Commission is virtually the same, as there were 36.17% cases pending for disposal for the same period. This undue delay tends to defeat the purpose of providing speedy remedy to aggrieved
consumer. However this tribunal is a special tribunal for medical malpractice claim and can decide the case expeditiously with the help of competent judges.

2 (e) Upholding the Reputation of Medical Professional

It is suggested that before the final decision, no publicity should be allowed. The reputation of the doctors in their profession matters a lot to them and can be adversely affected by these false, baseless or vexatious complaints. The complaints can cause irreparable damage to the fair name and respect of the doctor, though, ultimately nothing may come out of it. The damage (the maximum being Rs. 10,000/- as contemplated under section 26 of the consumer Protection Act 1986), which is awarded to the doctor, is no substitute of the harassment and ignominy of trial that he has gone through under the Consumer Protection Act, especially where the motive was to blackmail or to coerce the doctor. But as the Medical Tribunal System is concerned there is objective appreciation of evidence hence the possibility of admitting unnecessary litigations are rare.

2(d) For Common Court System for All Patients

One of the main draw backs of the consumer court is that they are not ready to provide remedy to patients from Government Hospitals and Health centers. Because of “Non-paid “service it will not come under the jurisdiction of Consumer Protection Act.\textsuperscript{16} This problem can be cured through the tribunal system. They can adjudicate cases both from the government and private hospitals. The controversy regarding paid service and non-paid service can be settled through the Medical Tribunal System. Every patient irrespective of whether he was treated at government or private hospital can approach this tribunal with a genuine case.

\textsuperscript{15} \textit{The Hindu}, February 14\textsuperscript{th}, 2009, p. 8
\textsuperscript{16} \textit{Indian Medical Association v.V.P.Santha}, AIR 1996 SC 550
2(e). For a ‘No-fault’ Compensation Programme

Under ‘No-fault’ compensation programme, the objective is to provide a quick, cost-effective and fair means of compensation to the victims of medical accidents. The ‘no-fault’ prefix means that the victims do not have to prove that the damage has resulted from someone else’s negligence and has occurred in circumstances which qualify within the condition laid down by ‘no-fault’ scheme for compensating victims of medical accidents. Under this, the affected patients and his relatives may be paid compensation without any inquest by the insurance companies from a fund equally contributed by patient, doctor, institution, and the government. According to Harvard, one of the consequences of the introduction of so-called scheme is improvement in the chances of detecting careless and incompetent medical treatment.

This may be helpful particularly to those injured who do not wish to pursue compensation because of the financial risk involved, but would be willing to pursue the case under no-fault scheme. The necessary condition for a claim to qualify under the ‘no-fault’ scheme is whether the injury could have been prevented by the alternative diagnostic or medical procedure or by performing the procedure differently. Harvard felt that the cost and delays involved in the present law of torts created formidable obstacles and there were little prospects of any radical reform in it. Therefore, a properly constructed ‘no-fault’ compensation scheme offers a feasible alternative which would be acceptable to most of the victims. In USA, such a system has been introduced in the states of Virginia, Florida, New York, Sweden, Netherland and New Zealand have also been practicing this ‘no-fault’ scheme for medical injuries since 1990.

---

19 Supra n. 19.
20 Ibid.
21 Ibid.
This concept of ‘no-fault’ compensation, which says that any person who suffers a physical injury must be compensated by the community irrespective of the cause and reason of such injury, is not new in our legal system. It already exists under the labour laws regarding compensation due to injury at workplace. \(^{22}\) So new provisions must be incorporated for ‘no-fault compensation scheme.’ It will be helpful for protecting the right of aggrieved patients.

2 (f) To Improve Faulty Procedure under New Law

Every action under Consumer Protection Act begins with an aggrieved patient lodging a complaint in writing with the Consumer Forum alleging that the Service hired or availed of by him suffer from deficiency in any respect. At this very primary stage the complainant is expected to furnish the form of Exhibits, certain documents pertaining to the case to establish a prima facie case. However, the difficulty that arises for the patients is that they rarely have access to these medical documents as they are generally not delivered to the patients, especially in cases where something goes wrong, on the pretext of confidentiality. Thus at this stage itself it becomes difficult for the patient to establish his case and many cases are dismissed summarily. The procedure that is followed after, is also equally complex. The procedure includes submission of evidence in the form of affidavit, examination of documents, cross examination of witnesses and several other formalities. This procedure leads to unnecessary delay. The patient is unable to submit anything before the court. The patient does not have any access to the hospital documents. The patient is unable to acquire even the copy of treatment chart from the hospitals where, the details of treatment are described. So a helpless patient would not be able to comply with the procedural formalities of the court. Thus changes are required in this matter.

\(^{22}\) Section 3 of Workman’s Compensation Act
The change that is being proposed in this scheme is dilution of standard of proof on the part of patient. Under the current system there are two stages before a case is established. First the patient proves that there was a negligent act which led to physical or mental injury and in the next step he is required to prove the fault of the doctor and establish that he was directly responsible for the injury. In the proposed system, patient would be required to establish the first step but not the second. Under this system the doctor will not be held personally liable and therefore there is no need for establishment of his personal fault.

2(g). Application of Judicial Mind in the Decision Making Process

Under the present legal system one of trickiest part is proving the negligence of doctor. The test applied for determining liability is the Bolam test, which apart from ‘reasonable care’ standard also validates the ‘generally accepted practice’ argument. Therefore the question that is left for decision by the consumer court is whether the act was done by the doctor under given circumstances is a practice prevalent among medical fraternity or not. This is a technical issue which involves appreciation of medical procedures and details and the courts in most cases rely on the evidence of expert witness. In most of the cases they blindly follow the opinion given by the witness without verifying the truthfulness of such evidence. And moreover since it is through these cases the medical fraternity sets standards for itself, the doctors are generally reluctant to give evidence, even in genuine cases, against their professional colleagues.

The primary fear being, that the standards that they set will be applicable to them also. Another ancillary effect of this procedure is that there is very little scope for applicability of judicial mind and the direct bearing of this, is that the law of medical negligence has not evolved and the principles applicable remain the same, irrespective of the fact that medical science has progressed in leaps and bound.

23 The Supreme Court upholding this principle in the case of Vinitha Ashoka v. Lakshmi Hospitals, AIR 2001 Sc 3914 again reiterated that, “A doctor will not be held guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical man skilled in that art”.

Through the proposed medical tribunal there is possibility of evolution of medical jurisprudence in India in accordance with the development of medical science. This is possible through the decision of expert panel. In this decision there is possibility for application of judicial mind and medical knowledge simultaneously.

3. **Bolam Test**

Having regard to the conditions obtaining in India, as also the settled and recognized practices of medical fraternity in India, there is a view that to nurture the doctor-patient relationship on the basis of trust, the extent and nature of information required to be given by doctors should continue to be governed by the *Bolam* test rather than the “reasonably prudential patient” test evolved in *Canterbury*. 24 It is for the doctor to decide, with regard to the condition of the patient, nature of illness, and the prevailing established practices, how much information regarding risks and consequences should be given to the patients, and how they should be couched, having the best interest of the patient. A doctor cannot be held negligent either in regard to diagnosis or treatment or in disclosing the risks involved in a particular surgical procedure or treatment, if the doctor has acted with normal care, in accordance with a recognized practice accepted as proper by a responsible body of medical men skilled in that particular field, even though there may be a body of opinion that takes a contrary view. Where there is more than one recognized school of established medical practice, it is not negligence for a doctor to follow any one of those practices, in preference to the others. There should be some legislative mechanism for getting statutory recognition for Bolam test.

4. **Fixing the Cost of Treatment within Affordable Limit**

There is a need to keep the cost of treatment within affordable limits. People in India still have great regard and respect for doctors. The members of medical profession have also, by and large, shown care and concern for the patients. There is an atmosphere

---

of trust and implicit faith in the advice given by the doctor. The Indian rarely questions or challenges the medical advice. There should be some legislative control over hospitals expenses so as to avoid exploitation.

5. **Patient-Centered Approach**

This approach encourages doctors to include patients as partners in health care processes. It encourages patients to ask questions, to seek second opinion, and to share responsibility for medical decisions.  

This approach requires effective doctor–patient communication. The doctor–patient communication has been described as an integral component of quality medical care. Poor communication on the part of the doctor is a major factor leading to patients and their relative’s dissatisfaction with health care.

A direct communication with the patients and his relatives prevents many problems. A patient has the right to full information about diagnosis and treatment possibilities. The doctor should give necessary information in way that is comprehensible to the patient. This is the cornerstone of developing better patient–doctor relationship. This approach requires that information should be formal, honest and truthful.

In this approach, the patient must be well informed in order to make healthcare decisions and work ‘intelligently in partnership with the doctor. Effective patient doctor communication can dispel uncertainty, fear, and it enhances healing and patient satisfaction. In addition, this requires doctor to disclose to patients the information about procedural or judgment errors made in course of care, if such information significantly affects care of the patients. So patient centered approach is the need of time.


27 *Ibid*. 
6. **Improving the Quality of Service**

Another drawback of this system of consumer redressal is that it does not address the issue of ‘sub-standard care’. Compensation can be claimed only for an injury that is the direct result of fault of a medical practitioner but there is no remedy for low standard treatment which does not result in any direct damage to the patient. In other words the current system does not provide any measure to ensure that the quality service be provided and maintained. Medical negligence is a mere instance of an injury being caused to a person due to fault of another. It is reflective of the medical and health standards of the country. It is for this reason that mere provision of compensation alone is not enough to deal with this issue. What is required is a proper mechanism to check the cases of medical negligence. One cannot forget that the purpose of law is not just to punish a wrongful act and give remedy to the adversely affected party but also to ensure that such deeds are not repeated again. A complete consumer care system should include steps for prevention of such incidents. In other words a mechanism should necessarily be developed to punish the guilty practitioner which in turn can serve as a deterrent to others. In the present system the consumer courts do not have power to take action against the doctors and this task is in the hands of the Medical Council of India.

The reason here again being the faulty procedure established by the law in this regard. For example, the MCI takes up disciplinary actions only when a formal complaint is filed by a member of public. However, since most of the victims of medical negligence are either not interested in getting the doctor punished or are not aware of the procedure to be followed for the same, the cases never come to the knowledge of the Council and no action is taken against the doctor. Apart from this, the Medical Council Act, 1956 does not lay down any procedure to be followed for conducting such enquiry or any time limits for the completion of the same. Such investigation is often done by adhoc committees and they take a long time to submit their findings, primarily due to the fact that they are not accountable to any one. To sum up there are rarely any disciplinary action instituted against doctors, guilty of negligence and hardly ever are the doctors punished for the same.
Under the proposed law there must be clear provision for imposing such disciplinary action against such doctors. This will serve as a deterrent for other doctors. Otherwise it will not make any improvement in the quality and the standard provided by the medical profession.

7. **For Compensation Scheme**

The patient under the scheme will be entitled to get minimum amount of compensation depending on the nature of injury and the amount that can be claimed will be fixed. However, the patient will have the option of either taking monetary compensation or non-monetary compensation in the form of future nursing care. So provision should be added under the new law for this kind of compensation scheme.

8. **Payment Mechanism of Compensation**

The payment mechanism would be different for private and government hospitals. For the latter, a medical negligence Compensation Fund would be established. With respect to financing of this fund, a certain minimum amount can come from Compulsory state Insurance against any sort of litigation of all the doctors working in the government hospitals and the rest from the State. A minimal fee can also be imposed on all the doctors at the time of registration or re-registration and this amount can also flow to the fund. For private hospitals, both the hospital and doctors should be insured for the safe rendering of service.

9. **Medical Screening Board**

A Medical Screening Board, comprising of senior doctor, senior lawyer and competent staff from the department of legal affairs should be set up. The function of this board will be to rule on the merit of the case before it can be process. A negative finding will not bar the patient from filing a suit, but the panel’s decisions will be admissible as evidence in court. Besides, the patients will know about the merits of the case before they

---

28 Something very similar to the schedule, under Employees State Insurance Act or The Motor Vehicle Act.
formally approach the court. If there is genuine dispute between the patient, hospital and doctors, the matter can be referred to the tribunal after screening of documents. It will reduce the number of unnecessary litigation and burden on the court. To that extent the reputation of medical profession will be in safe position. It will also save their precious time from unnecessary litigation. This screening board for the documentary examination of complaints to check whether there is a genuine case or not has to be implemented under the new law.

10. **Full Disclosure of Information Regarding Therapeutic Application**

When the course or technique favoured by a physician is not one of the professionally accepted alternatives or practices; and it entails risk or ranges of therapeutic efficacy significantly different from those associated with acceptable practice, a more guarded application of the duty to afford patients the benefit of one’s superior knowledge or special insight is needed. This may present a dangerous situation for both the patient and his physician. The patient should be informed of the full range of professionally acceptable alternatives, and only then should the physician communicate the approach he favours and the reasons for his preference. Full information should be disclosed to the patient in accordance with applicable consent doctrine and in any event should include information about the range of therapeutic alternative irrespective of whether or not such information is ordinarily required under the informed consent rule of the jurisdiction in question. Thus the physician should not only disclose information regarding professionally acceptable alternatives, but should, in accordance with the suggested guidelines, also communicate other possible courses based on the physician’s superior knowledge or special insights. This kind of full disclosure of information helps the patient to choose the better one by consulting with other knowledgeable medical person. So the patient will get an opportunity to take a second opinion of some other doctors.
11. For Incorporating the Following Duties as Statutory Duties of Doctors

A wise doctor always takes preventive steps to avoid litigation rather than inviting it. The preventive measures are the following.

(1). When condition of a patient deteriorates for one reason or the other, the doctor should take the relatives into confidence by politely explaining the situation.

(2). The doctor should always obtain individual consent in writing, preferably in presence of a witness.

(3). A good doctor will always be optimistic but at the same time should never draw a colourful picture about recovery of a patient, otherwise the dissatisfied patient or relatives may allege that the doctor had misled them.

(4). A doctor should always examine a female patient in presence of a nurse or her female relatives, so that no allegation may be made regarding the doctor’s behavior or conduct.

(5). He should explain to the patient about approximate expense of the treatment before starting the treatment.

(6). He should never do experiments on the patient without consent, and without practical experience.

(7). He should keep Medical record of the patient up to date, which would constitute good evidence, and it will prove whether proper care was taken from time to time.

(8). He should never try to change or manipulate medical record of the patient, as such a change may prove the doctor’s negligence.

(9). A doctor should never issue a bogus certificate and he should always keep a complete record of the certificates issued by him and preserve the record at least for a period of 5 years.

---

(10). After accepting the patient and starting the treatment, the doctor should not leave it halfway without the patient’s consent and the doctor should attend to his indoor patients round the clock.

(11). Fully inform a patient of his condition.

(12). Notify a patient of the results of a diagnosis or test.

(13). Inform the patient of the need for different treatment or refer the patient to a specialist.

(14). Continue medical care until proper termination of the relationship.


(16). Not to abandon a patient, and also make arrangements for treatment during absences.

(17). Equal treatment to all patient irrespective of their ability to pay for the same.

(18). Due diligence in treatment in providing all necessary care.

(19). Obtain a patient’s informed consent before performing a medical procedure.

(20). Warn others of exposure to communicable and infectious disease.

12. **Incorporating the Following as Statutory Rights of Doctor**

In spite of taking the aforesaid preventive measures, if a complaint is filed against the doctor, he can put forth the following defenses as a matter of statutory right.

(1). **Accident**: (e.g. An instrument may slip from the mechanic’s hands, car brakes may fail and so on). Frequently things go wrong during medical treatment even if best care or precaution is taken by the medical attendant. Needle may break, glucose pin falls on the ground, and instrument may not work during surgery. But these circumstances are beyond the control of the doctor and they are regarded as mishaps and not negligence.
(2). Well recognized and approved practices, and precedents accepted as proper by a responsible body of medical men skilled in a particular art.

(3). The doctor may plead that in a given circumstance, he had to handle the case with limited resources. For example, in a small town, facilities of blood transfusion, scanning, artificial ventilator, Intensive Care Unit, drugs etc may not be available and if the patient does not improve, then the doctor may not be held liable.

(4). **Contributory negligence**: The patient also has certain duties towards the doctor himself. He is expected to meet the standard of care of a reasonable patient. If he is found to be negligent contributory, his compensation will be reduced. Failing to disclose a material fact, failing to stick to the treatment, failing to cooperate during treatment and failure to follow the instructions, leaving the hospital without notice or against medical advice are all examples of contributory negligence on his part.

(5). **Emergency**: The doctors are bound to give emergency treatment to save the life of a patient in cases of accident, and if the treatment is bona-fide, the doctor is not guilty of negligence even if the service is not up to the mark.

(6). **Error of Judgment**: If the doctor commits a mistake that is genuine and accepted by medical profession as a mistake likely to occur, such error of judgment would not be regarded as negligence.

(7). **Known Complication**: Certain complications are known to follow every treatment or procedure and if such complication occurs, the doctor will not be held liable for negligence.

(8). **Bona-fide Opinion**: If a doctor chooses one of the approved treatments considering that as the best in his opinion for a particular patient, it is not negligence itself.

(9). **It is most desirable for a doctor to have a full insurance**: The insurance is the best defense and also give mental peace over and above the financial relief.
Above all the doctors should maintain a regular medical record of the patients, containing the complaints, symptoms and other reports with date and time in detail. The record will also include the case history, laboratory test reports, diagnosis, prescriptions and developments from time to time. Otherwise it can be considered as negligence on the part of physician.

13. **Incorporating Following as statutory Duties of Patients**

A patient has a duty to co-operate with a physician and participate in treatment and diagnosis. For example, a patient does not have a general duty to volunteer unsolicited information but is required to disclose a complete and accurate medical history upon questioning, by a physician. A patient also must return for further treatment when required. Failure to co-operate or participate in treatment may be detrimental to the patient if and when he proceed against the doctor for malpractice, as there will be only a limited recovery, depending upon the circumstances of a case.

14. **For Incorporating Provision for Standard of Care of Specialist**

The standards of care of specialists are higher when compared to other doctors in the same field under similar circumstances. This typically means that specialist, because of their advanced training and knowledge, are held to have a higher standard of care than that required of general practitioners. Even though not certified as specialists, those who hold themselves out to be specialist or perform procedures normally done by specialist will be held to a specialist standard.\(^{30}\) So there must be legislative guidelines on the standard of care of specialist. And also there must be some documentary certification for declaration of specialist status under Medical Council Act.

15. Preventing the Service of Quack Doctors.

A physician’s conduct must always meet the standard of care set by the profession, or else he may be liable for Malpractice. Physicians and surgeons must possess and exercise the same level of skill and learning ordinarily possessed and exercised by other members of their profession under similar circumstances. There must be some mechanism for enlisting the name of quack doctors and qualified doctors under the Web-site of Indian Medical Association or the site of concerned State Health Department so that the people can avoid service of quack doctors. It should be incorporated as the statutory responsibility of Health Department of the concerned State Government.

In USA, way back in 1989, the Congress created the National Practitioner Data Bank (NPDB) to mandate collection of information regarding incompetent practitioners. NPDB also collects information regarding disciplinary action taken by State Medical Council and Dental Boards. NPDB maintains an Internet site and makes available all information regarding registered practitioners\(^31\). So the patient can choose the service of competent doctors and can identify the quack doctors.

16. For Revealing Confidential Information as Statutory Duty

A physician stands in a fiduciary relationship to his patients, meaning that the physician must always exercise the ut-most good faith and trust when dealing with patients. A confidential relationship must exist between the parties because a patient must feel free to disclose any information that might pertain to treatment and diagnosis, the physician has the professional obligation to keep information confidential in the absence of patients consent. But a physician cannot attempt to shield his own incompetence by refusing to disclose information. Moreover a physician may have a statutory duty to reveal information concerning a patient. Doctors are required to provide information regarding birth and death, child abuse, and contagious or infectious disease etc.

\(^{31}\) Ibid.
17. **For Incorporating Provisions for Immediate Medical Aid as Statutory Duty**

All Government Hospitals, Medical Institutes should be ready to provide the immediate medical aid in all the cases irrespective of whether they are Medico-legal cases or otherwise.\(^{32}\) If there is any non-compliance to this statutory duty, the government must have the power to cancel the license issued to the hospital. The Government should have the power to conduct such inquiry based on some complaints filed by aggrieved patients. Such provisions should be incorporated for the strict implementation of this duty.

18. **For Appointment of Medical Audit.**

Medical audit is a method of objective evaluation of the quality of medical care. This is conducted by the service providers themselves (in house doctors and Hospital administrator) supervised by a peer group. It facilitates self assessment, by looking at current medical practice, comparing them with set standards of medical care and suggesting changes for implementation and improvements.\(^{33}\) It helps detect deficiency in medical services provided, to improve attitude, skill and knowledge of the providers and to ensure collective responsibility and accountability. Medical audit is designed to measure the care received by patients as judged by established standards and criteria. The purpose is to identify both strengths and weakness of policies and procedures, and ultimately to correct deficiency or deviation from accepted standards.\(^{34}\) Medical audit involves audit of structure, process, outcome, patient satisfaction and cost. An effective medical audit system for improving health care facilities should have a performance parameter. It should help to improve cost efficiency, consistency and quality of care as per the changing market demand in cases of quality ethics and the consumer laws.

\(^{32}\) Paramand Kattara v. Union of India AIR 1989 SC 2039.


The audit encourages doctors and nurses to integrate each others plans for patient care, improve their communication, identify needs for revision of policy and procedures and reassess equipments, personnel and other aspects of patients care. There should be provision under the new law to incorporate Medical Audit System

19. For the Organization of Quality Control Circle

A quality control circle is a small group of usually eight to ten staff members who work in the same department under some supervision. They meet voluntarily on a regular basis to identify, analyze and develop solution to problems in their specific work methods. They will collect information regarding patient satisfaction, employee satisfaction and reduction in cost.

This may require data collection which is helpful for the health department and hospital management for improving their quality. Some problems can be solved directly by the circles, others can be presented to management with recommended solutions and it is committed to make them work. Documentation of quality control circle’s activities becomes part of the overall hospital quality assurance program.

The operative precept in the concept of quality control circles (QCC) is “the man wearing the shoe knows best where it pinches” which means the employee working at the micro level is the one who is most familiar with the problems related to his work area. Therefore, the employee’s innate familiarity and their ability are together used to find the solutions to the problems.

Many organizations in the manufacturing sector have adopted the concept of QCC. The State Bank of India, Bhopal Quality Circle has been the first instance of successful integration of the philosophy of QCC in a service industry. The quality circles in banks have yielded results that are truly novel. The problems that the staff

35 Ibid.

learnt to live with or had ignored hitherto were solved. There has been an attitudinal metamorphosis among the members of QCCS. This radical transformation in the work ethics has manifested itself in more responsible behavioural patterns and improved service. The health institutions can adopt this concept in order to improve the services provided to patient. Service provided by the health institutions cannot improve unless the employees at all level including the hospital administrators, doctors, or other paramedical staff is deeply involved.

20. For Education of Health Care Provider

Education of Health Care providers is the need of time. So necessary provision should be incorporated for physician’s discipline and public education.\(^\text{37}\) Grant should be provided for the same. Grants should be set up to conduct programs for informing the public regarding the existence of professional licensing and disciplinary boards. The grants may also be issued to educate health care professionals regarding “quality assurance of services, risk management, and medical injury prevention.”

The hospital should formulate and enforce some rules and policies to ensure patient’s safety. Hospital should make by laws and regulations or committees to frame adequate guidelines for disciplinary actions. Thus they can prevent corporate liability arising out of negligence to certain extent.

These are the main suggestions recommended for reforming the existing legal system. Medical Negligence Dispute needs the care and protection of effective laws with sufficient technical frame work. It is the need of time to balance the rights of doctors and patients in a harmonious way. Doctors are like visible Gods. There must be strong and trustworthy relation between patients and doctors. The objective should be to evolve a system in which conflicting interest of the public and medical professionals in cases of medical negligence can be balanced in the best manner.