LIABILITY UNDER CONSUMER LAW

Introduction

Practice of medicine is as ancient as the existence of human race. Originally the priest functioned as preacher, teacher, judge as well as healer. He was the first physician. With the passage of time this job of a physician graduated into an independent profession. In the earlier era ‘Physician’ was treated as ‘next to God’. Gradually, his social structure reduced from ‘next to God’ to a ‘friend, philosopher and guide’ and then to a respectable professional and today to a ‘service provider to health consumers. This down slide in the social position and esteem of physician seems to be the result of deterioration of social values, materialistic approach to life, commercialisation of medical profession, higher expectations and awareness of either rights and privileges by patients and increasing consumer activism.

Earlier, the relationship between the doctor and the patient was considered very sacred. However, from the fifth decade of the 20th century, there has been an increasing amount of doctors and their patients ending up in the law courts. Patients have now become better educated and informed about the nature of disease and treatment and perhaps, with justification, began to expect better results and more transparency in the treatment. ¹

The profession of medicine has benefited mankind immensely through restoration of good health. Medical service mean assistance or benefits pertaining to medicine or its practice offered to another ie., the preservation of health and of treating disease for the purpose of care. ² It should be clear, therefore that medical service implies delivering quality medical care to the community (ie, service of ‘mankind’), in treating and curing affliction of the human body.

¹ Dayal Arvind, Legal Aspects of Health Care ,Indian Journal of Clinical Practice, Vol 8, No:4, January, 2001, p.68

Generally medical service includes the service rendered by the hospitals (both government and private), nursing homes, health centers, clinics medical practitioners (physicians, surgeons, and these practitioners like ayurvedic, homeopathic or any other systems of medicine or surgery), chemist, diagnostic centers, paramedical staff, nursing, staff and other allied staff.

According to the New International Webster’s Comprehensive Dictionary of the English language, doctor means a qualified practitioner of medicine or surgery in any of its branches and patient means a person undergoing treatment for disease or injury.³

For the detailed study of this chapter the position of consumer law in England, America and India has to be discussed in detail. Consumer law has different applications in these countries. Following are the explanation regarding the same.

1. Consumer Liability under the English Law

There is no doubt that in the United States, Britain, Australia and many other countries medical negligence cases are on the increase. In Australia, this has produced conflicting proposals. The president of the Australia Medical Association, Dr. Kerryn Philips, told a seminar in Sydney in February 2008 that the tort reform is highly necessary.⁴

³ *Ibid.* at p.374

⁴ “Tort law reform is a crucial issue for the Australia medical profession, and it would not be an overstatement to say that the situation has reached boiling point. Over the past eighteen there has been a growing chorus of call for the(Australian Medical Association) to work with government to do something to address the blow- out in medical indemnity premiums. This was brought to a head last year with a call from the Victorian Medical Indemnity Protection Society demanding a full year’s substation from all members. We have reached a situation where clinicians in a number of fields are obliged to carry any unrealistic premium burden. This cannot be sustained on a long term basis. The effect are already being felt. Aneodotally, we are aware that many obstetricians are leaving obstetric. One of the first groups to “down tools” is the rural GP Obstetricians. These rural services are not easy to replace and communities in rural areas are already frustrated and angry about their declining health
It was reported that up to 40,000 patients die in a year in Britain as a result of medical error. This is about four times more than those who die from all other types of non-deliberate civil wrongs. The report also studied non-fatal errors in drug prescription and infections which are said to affect 280,000 people in the United Kingdom each year with an annual additional cost of remedial case of $730 millions in England alone.  

Dr. Vincent’s results were not dissimilar to those produced a few weeks earlier, published by the Kellogg Foundation concerning experience in the United States. That report concluded that 70% of the errors (and 155,000 deaths) in that country resulting from medical misfeasance was avoidable. Even if one were to discount these cases, significantly for patients and their families who were philosophical about their fate, it cannot be denied that in many such cases legal proceedings for negligence and breach of contract would be completely justifiable. Such proceedings would sanction the losses of particular patients. They might also instill a greater measure of responsibility and reinforce professional efforts to ensure accountability. A democratic society is not likely to tolerate a legal system which denies a remedy to such people, at least in serious cases.

The most radical solution is to abolish tort recovery by statute and to replace it by a comprehensive system of exclusive monetary compensation for all service. "If we look at the trends in the United States, it is clear that the writing is on the wall for us here in Australia. The American experience is a prediction of things to come in Australia and we would do well to take note." The Hon Justice Michal Kirly AC CMG, Medical Malpractice-An International Perspective of Tort System Reforms.

5 Medical Malpractice Liability  http://www.loc.gov/law/help/medical malpractice
liability/intex.php visited on 29-09-2009

6 Ibid.

7 Vincent et, at, BMJ 2001, 322 517-519  information centre for health and Social Care
presetatio%2HUW%20Williams visited on 25-5-2009
“personal injuries by accident”. This is a measure that was adopted by the parliament of New Zealand following the Woodhouse Report.8

Medical service and health care have grown tremendously in terms of accessibility over the last few years, and consequently there has also been a rise in the number of medical negligence or malpractice. There has also been a rise in the number of medical negligence or malpractice suits filed all over the world. The existing system of malpractice or negligence either does not deter or is over deterrent. On one hand, due to the trouble with litigation, very few victims of negligence file a suit, ensuring that some doctors get away lightly with negligence. Other consequences of such a system could be that some doctors become very cautious and the threat of suits results in substantial amount of unnecessary “defensive” medical practice. This leads to increasing cost within the field of medicine.9 In Developed countries like U.S and Europe, doctors preferred to get insured for their negligence act. It is important to look at insurance policies in greater detail. The basic principle of liability is simple. The company and the insurer enter into an agreement where, in exchange for the premium paid by the insured, the company agrees to defend any claim against the insured that lies within the limits of the cover of the policy. Liability insurance, unlike what was originally feared, has not undermined the system of tortious liability. What has instead happened is that the insurer is substituted by the insurance company for the insured as tortfeasor in most cases, leading only to a change in the parties to


New Zealand accident compensation scheme came into operation on 1st April 1974. It was based on an insurance model that provided cover for all, regardless of fault or cause of injury. The model was recommended by a royal commission in its report. In 1967 the royal commission produced Woodhouse Report, named after its chairman Mr. Justice Woodhouse. The Woodhouse Report Signaled a significant shift in how News Zealand dealt with the consequence of injury. It proposed a move away from a litigious, fault based system, towards a completely new ‘no fault ‘approach to compensation for personal injury.

9.  Ibid.
the dispute, but not to the legal principles applicable. The insurance company owes a duty to indemnify the insured and settle outstanding claims of the victim of negligence.\textsuperscript{10}

Another appeal is alternative Dispute Resolution for all health care liability except when related to Public Health Services Act. A limitation period of one year to file suits relating medical liability, subject to maximum gap of 3 years in certain specific cases. Punitive damages or double compensatory payment of a maximum of $250,00.\textsuperscript{11} Periodic payments if the damages awarded are more than $50,000, judicial consideration (as admissible evidence) of the fact that the victim acquires collateral benefits as well.\textsuperscript{12} Limitations on lawyer’s fee, creation of a government controlled National Fund that will automatically insure insurers and underwriters to the tune of maximum of $250,000. Broadly, these suggestions can be accepted in India as well as, as a mode of reforming the law. Since the incidence of punitive damages in India is not particularly high, and we do not follow the jury system, the reforms relating to the limitations on quantum of non-economic and punitive damages may be somewhat irrelevant. However issues such as limiting the lawyer’s fee, creation of national insurance fund, and consideration of the fact that alternative compensation already exists. Some countries such as Sweden have thus come up with a patient insurance scheme, whereby though the insurance is taken by the doctor’s and the hospitals it is patient centered in nature. At the same time this scheme would be like a normal social security scheme where all, illnesses are covered by it, but it only becomes applicable on the fault of the doctor. It is different from medi-claim policy. The benefits of such a system are that firstly, the standard of care is such as that of specialist whether or not the concerned doctor possesses such a degree of skill. At the same time even if the accident were unavoidable, the indemnity will apply, if the treatment result in injury disproportionate to the initial illness. At the same time, there are economic considerations which have to be taken into account while imposing a scheme such

\begin{thebibliography}{9}
\bibitem{11} The objective Analysis of the Medical Negligence case-http://www.experts.com/show Article. Asp? Id=95 Visited on 29-09-2009
\bibitem{12} \textit{Ibid}.
\end{thebibliography}
as this. Patient himself can also get insured for his treatment in case of any exigency or emergency. Different kind of medi-claim policies are offered by insurance companies taking note from general ailment to most serious one. However, the claims are granted when the ailment for which claim is needed is not pre existing one.

In India, at one level the number of victims of negligent medical treatment who are able to get compensation, even after *V.P.Shanta*, is minimal. A great number of victims never get any redress at all. At the same time, since health care services and awareness is growing all the time in India; the doctors are more and more open to litigation by claimants, bona fide or otherwise. We have seen that in the United States, where awareness and litigation levels are much higher than in this country there has been a crisis in the medical profession due to the cost of paying off damages or paying insurance premiums. Therefore the aim of Indian law should be to create a visible system whereby the medical professional does not bear too heavy an economic burden, but at the same time, the victim has the best chance of recovering speedy and meaningful compensation. In this regard, the reform suggested in the area of insurance by the American Senate in the form of draft Bills can be a good model to adopt in India. Some of these proposals included creation of national re-insurance fund that will go a long way in ensuring that insurance premium does not become unacceptably high. Furthermore consideration should also be had to the availability of alternate compensation mechanisms, which if introduced in India at an early stage, will bypass the crisis situation that the United States Medical Insurance professions have seen. These alternate compensation systems may be on the lines of no fault liability scheme or through a fault based administrative systems, or even by negotiation and conciliation between the parties.


13 Supra, n.5
A. Position of medical Negligence Law with Respect to U.K.

Consumer Law

The position of medical negligence under U.K consumer law is relevant in this context. It has already been discussed in the section dealing with the U.K law that it has become, over the years, increasingly difficult to establish a case for medical negligence. The position has been diluted in the wake of consumer rights against deficient services of practitioners. In *Clark v. MacLennan*, an attempt was made to shift the burden of proof to the defendants or erring doctors. The court stated that, “when an injury is caused which should never have been caused, common sense and natural justice indicate that some degree of compensation ought to be paid by someone. As the law stands, in order to obtain compensation, an insured person is compelled to allege negligence against a person of the highest skill and reputation. “Such a stand is now being considered by the House of Lords where the proof of medical negligence must not rest, at least in a matter of civil nature, so heavily on the complainant.

The exercise of the skill of medical, practitioner must be reasonable. The term reasonable has been found to mean that the standard of due caution in undertaking treatment must not be very high or very low. It must be the standard which is reasonable. The test of reasonableness also does not apply keeping in mind the reasonableness of a highly skilled person. Reasonableness must, in this case, be of a person ordinarily skilled in the art of medicine. This has been the thrust of *R.v. Bateman* the Bolam’s case, as well as all judgments subsequent to it. The position of law in this regard has been rather undisturbed.

In respect of the issue of deviation from accepted practice, the position even under consumer law is that mere difference of opinion does not open the case of doctor for medical negligence. If the course adopted by the doctor was accepted as

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14 [1903] 1 K.B. 155
15 (1925) 94 L JKB 791
one of the possible courses that would rationally and reasonably be taken under the circumstances, liability will not be thrust upon the doctor. Also, the burden of proof of the complainant is not discharged if the court is not able to select between or among a set of alternatives present before it.

The basis of liability in consumer law is the existence of harm and not the measure of it. Measure of harm is the test of criminal liability, loosely worded; liability under consumer law is strictly involving no intention to cause harm. Going by this description, and applying all the parameters that have been laid down in regard to professional negligence in consumer law there is no reason why doctors also should not be made liable if there is harm resulting from their unreasonable exercise of care in respect of the duty they owe to their patients.

It would be useful and apt to state that medical profession is regarded in highest esteem because of the nature of service they provide to humanity. This consideration has always weighed with judges deciding cases involving doctors. If a doctor fails to exercise reasonable skill and care in the exercise in the performance of such duty that is considered as service to humankind, he should not be allowed to take refuge of the nature of duty which he has, in a sense, disregarded by not being reasonable on his own part. There is enough protection given to doctors when they are properly exercising their skills. For all other purposes and contingencies, they should be placed along with other professionals, as has been pointed out in Gregg (FC) v. Scott 16 which has already been referred to earlier.

With the increase in commercialisation of medical services, it is only fair that, while maintaining the sanctity attached to the profession, negligent doctor must not be allowed to go free. Therefore, as a check on the professional conduct of doctors, consumer of tortious liability should remain. 17

16 All ER 2005 Vol.7
17 Wisconsin Civil Justice Council, INC http://wwwwisciviljusticecouncil.org/issue-resources visited on 29-09-2009
One of the most important aspects of consumer protection is the problem of claiming compensation against a producer when the goods have been defective and have caused injury (or death) to a person or damage to property. The system concerned with the operation of the basic rules of liability of manufactures, retailers, importers and installers for defect in the products they supply is called, short product liability. In U.K, consumer liability stands as an integral part of tortious liability under U.K Consumer Protection Act. Consumer liability in America is entirely different.

11. Position in America

Consumer Liability in America is basically based on three kinds of liability, Product liability, Insurance Liability and Enterprise liability. Hospital and physician provide to patients products that are manufactured by others. These liabilities are explained in the subsequent discussions. Position of consumer law in India is being discussed for better understanding of law a consumer can avail of protection under medical service.

111. Consumer Liability Position in India

In India Consumer Law is in advanced position as compared to other countries. Doctors need scientific knowledge, technical skill and above all human understanding. Those who use these with courage, with humility, with wisdom and in accordance with medical ethics provide a unique service to either fellow-men or women, and build an enduring edifice of character within themselves. It is, therefore a noble profession. Traditionally, the family doctors were considered to be a friend, philosopher and guide for the sick. The relationship between the patient and the doctors was considered to be very sacred; it was based on natural


19 The relevant parts of ‘Code of Medical Ethics.’
trust and faith. Increased mechanisation and commercialisation of the profession has brought in an element of dehumanisation in medical practice.\textsuperscript{20} Health care has now been reduced to a business which determines the doctor-patient relationship.\textsuperscript{21} It is in this context that the question of consumer protection has become significant in the medical profession.

### A. Consumer Protection in Medical Services

The Consumer movement is gaining momentum across the world in all spheres covering both goods and services. With increasing public awareness about their right, the patients as consumer now insist on getting their money’s worth in terms of quality health care.\textsuperscript{22} The theme for the World Consumer Rights Day, celebrated on March 15, 1989, was “The Right to Responsible Health Care.”\textsuperscript{23}

Later\textit{ Justice v. Balakrishna Eradi President Consumer Redressal Commission,} on April 27\textsuperscript{th}, 1992 delivered a landmark judgment\textsuperscript{24} in the history of medical profession in India, in which it was held that the patient is a consumer under section 2 (1) (a) of the Consumer Protection Act, 1986 and hence, entitled to invoke the jurisdiction of a redressal fora and that the activity of the opposite party (hospitals and doctors) constitute service as defined under Section 2(1) (o) of the Act, since consideration has been paid by the patient to the hospital for availing the services. It was also held that the legal heirs of the deceased are also considered as consumers and they are covered under this Act.

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\textsuperscript{20} Phatnani Pentium p, Medics-Legal aspects of Doctor-patient Relationship, \textit{Express Pharma Pluse}, 2001 Nov;30-p.5


\textsuperscript{22} Vaz Watter, Corpra-primordial prevention and pre-emption, \textit{Indian Journal of Clinical Practice}, special issue of Medilaw, May, 1996,p.34


\textsuperscript{24} \textit{Cosmopolitan Hospital and Anr. v.Vsantha P.Nair} (First Appeal 48 of 1991) and \textit{Cosmopolitan Hospital and Anr v.V.P. Shantha and others} (First Appeal No.94 of 1991) Consumer Protection Judgments CPJ 1 (1992), CPJ 302 (NC)
The judgment of the National Commission sparked off a country-wide controversy, while some people were in favour of the decision and asked for inclusion of even free medical services provided by government hospitals within the purview of the Consumer Protection Act 1986, others criticised the decision. Later the issue was extensively debated upon in the media, in technical scientific journals (medical and non-medical), and in seminars and conference. There was also a considerable debate on the impact of the implementation of the CPA to on doctor-patient relationship. The entire medical profession was disturbed by the judgment of the National Commission. The Indian Medical Association (IMA) vigorously opposed it.\textsuperscript{25} Members of the medical profession were of the view that if the medical service comes under the CPA, the patient-doctor relationship would be affected. \textsuperscript{26} The doctors would always be in a state of fear psychosis. \textsuperscript{27} They would then ask their patients to go in for all sorts of investigations, consultation, and would take medical indemnity insurance, which would mean considerable increase in cost of treatment and this would invariably be a burden on the patient.\textsuperscript{28}

There are some arguments in favour of this new step. The main arguments given in favour were that it was in this forum that a victim could get compensation.\textsuperscript{29} Consumer law also provided speedy, cheap and accessible remedy. As a result, medical profession has become totally commercialized \textsuperscript{30} and it was no longer a noble profession and the medical professionals were conducting

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\item \textsuperscript{26} Ravendran T.N.B, Consumer Protection Act and Doctors, \textit{Souvenir 69th All India conference of India Medical Association}, 2001 December, pp.25-30.
\item \textsuperscript{27} Ibid.
\end{itemize}
themselves without any sense of fear of liability against negligence and malpractice.\footnote{31} As a result the doctors were increasingly indulging in malpractice.\footnote{32}

Even the various High Courts and State Commission were having different views on this aspect. In certain cases it was held that medical services are covered under the Act\footnote{33} whereas the contrary view was that such services are not covered under the Act.\footnote{34}

Finally, the matter went to the Supreme Court and the landmark judgment in the case of \textit{Indian Medical Association v. V.P.Shantha} \footnote{35} on November 13\textsuperscript{th}, 1995 brought the whole debate to a close. It affirmed that the service rendered to a patient, both medical and surgical, is covered under the Consumer Protection Act, 1986. It was thus held that the entire Medical Profession has come under the perview of the CPA.

In this landmark judgment, Supreme Court expressly laid down certain guidelines to ascertain which services are covered and which are excluded. However, broadly speaking, the medical services are covered under the provision of the Act if they are paid services. So the hospital is liable to take reasonable care about the treatment of the patient, if the services of the hospital are hired by the patient. When a patient is admitted to the hospital on payment and put in charge of a doctor, what really takes place is hiring of the service of the doctor by the patient. If the hospital provides any other service, the patient is actually hiring these services also.\footnote{36}

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\begin{itemize}
\item \footnote{31} \textit{Supra,} n. 5
\item \footnote{32} Bal A, Medical Councils: Failure to enforce Code of Ethics, \textit{Health for the Millions}, Vol.18, No.6, 2001, pp. 11-14.
\item \footnote{33} \textit{Supra,} n. 24
\item \footnote{34} \textit{Ibid.}
\item \footnote{35} AIR 1996 SC 550
\item \footnote{36} \textit{Muralidhar Eknath Masane v. Sushrutha Citizen Co-op. Hospital} 1995 (1) CPR 606 (Bom)
\end{itemize}
Again the judgment of the Supreme Court is expected to have major repercussions. On the one hand, there are possibilities of benefits in the form of speedy decisions, inexpensive justice, simple procedures, relief to the victim in the form of compensation, improved quality of patient care and doctors becoming more cautious. On the other hand, there are possibilities of adverse effects which include increased cost of treatment, defensive medical practice, refusal to attend patients, especially in case of emergency, and deterioration in the 'humane’ relationship between doctor and the patient.

Regarding the claim for damages in the cases of medical negligence, prior to the present enactment of the consumer Protection Act, 1986 they were maintainable in the Civil Courts and under the provisions of the Law of Torts. The enactment of the CPA Act has provided a machinery to deal with the cases where there is an allegation of Medical negligence or deficiency in service. The proceedings under the Act are speedy in nature in comparison to civil cases and that too without any court fees. The enactment of the present Act has not taken away the jurisdiction of the civil court but has provided an alternative remedy. The Act provides a forum to the victim of medical negligence or deficiency in medical services which enables him to get cheap and effective remedy. The Act revolutionised and brought about changes in the conventional understanding of the medical profession. For further understanding a detailed discussion of the Consumer Protection Act is necessary.
B. The Consumer Protection Act, 1986

The Consumer Protection Act, 1986 was passed by the Indian Parliament in December 1986.\(^\text{37}\) The first amendment to the Act came into force on June 1991 and further the Act was amended by the Consumer Protection (Amendment) Ordinance \(^\text{38}\) (No:24 of 1993) dated June 18th, 1993.

The Act provides the definition of the various terms used in the Act. Some important definition having a bearing on its application to service rendered by medical profession was not expressly or categorically included within the definition of services. But it is clear that two types of services ie, services free of charge or the service under a personal contract were expressly excluded from the purview of the Act. Hence, the services, which are free of charge or under a contract of personal services, are not covered within the definition of the services under the Act and any claim with respect of such services, will not come under the jurisdiction of the CPA.\(^\text{39}\)

Later it was held by the National Commission\(^\text{40}\) that the definition of service has a broader meaning. It is made available to potential user when parliament has unambiguously defined the expression ‘service’ in such broad language and in widest amplitude. It is further held that the activity of providing medical assistance for payment carried on by hospitals and member of the medical profession fall within the scope of the expression ‘service’ as defined in section 2

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40 “it is well established principle of statutory construction that where the words of the statute are clear and unambiguous, they have to be give their full asset and their ambit cannot be cut down by reference to the preamble of the Act, the statement of the objects and reason’s apprehended to the Biller to the debates and speeches on the floor of the Legislature /parliament. The expression ‘service’ has been defined in section 2(1) (0) as a meaning “service of any description”.
Finally, it has decided by the Supreme Court of India in a landmark judgment that the medical profession is covered within the definition of service and that will come under jurisdiction of the Consumer Forum.\textsuperscript{42}

The definition of service excludes two types of service, viz(i) service rendered free of charge (ii) service rendered under a contract of personal service. However, in some situations this can be misused and exploited. Instances are not uncommon where the trader under the garb of rendering service free of charge forces his consumers to buy his products. Free camps for providing various treatments like eyes, ears etc are generally being organised by pharmaceutical companies or with the help of their companies by private organisation. Outside these camps, the companies usually put up their stalls, for selling their products. Generally the doctor’s treating the patient at these free campus advice the patient to buy medicines only from the sponsoring companies. This practice is nothing but unfair trade practices, which usually escapes the purview of the Act. The meaning of free services and meaning of contract for personal service are to be examined in detail.

\textbf{a. “Free of Charge”}

The term “Service Free of Charge” has not been defined under the Act the Supreme Court has through several decisions sought to make this clear by stating that in Indian Medical Association,\textsuperscript{43} where the Apex Court observed that the medical practitioner, Government hospitals/ nursing homes and private hospitals/nursing homes broadly fall in these categories(1) where services are rendered free of charge to everybody availing the said services,(2)where charges are required to be paid by everybody availing the services, and (3)where charges are required to be paid by person availing services but certain categories without any charge. The doctors and hospitals who render services without any charge and

\begin{itemize}
\item \textsuperscript{41} \textit{Ibid.}
\item \textsuperscript{42} \textit{Ibid.}
\end{itemize}
the person, who is availing such services would not fall within the ambit of “service” under section 2(1)(0) of the Act. The payment of a token amount for registration purposes only, would not alter the position in respect of such doctors and hospitals. So far as the second category is concerned, since the service is rendered on payment basis to all person they would clearly fall within the ambit of section 2 (1) (0) of the Act. The third category is doctors and hospitals providing service to the patient on payment basis. The expenses incurred by such doctors and hospitals to patient undoubtedly fall within the ambit of section 2 (1) (0) of the Act. The service rendered to patients free of charge by the doctors and hospitals in category (3) is not excluded by virtue of exclusionary clause.

According to consistent opinion of State Commission Delhi,
Karnataka,
Madras,
Punjab,
Rajasthan,
Maharashtra and Madhyapradesh, the patient availing of the facility of medical treatment in a hospital run by the Government is not a consumer. But State Commission, Orissa held that the services rendered by the doctors free of cost in Government hospitals are within the scope of scrutiny by the consumer Forum. But later, the National Commission and also the apex court in the case of Indian Medical Association v. V.P. Shantha laid down that the services rendered by the medical practitioner or hospital or nursing

44 Smt. Ran Kali v. Delhi Administration 1(1991) CPJ 309 (Delhi)
46 Kadarkari Nadar v. Rakkappan 1994(1)CPR CPR 359(Mad)
48 Hanuman Prasad Darbun v. Dr.C.S. Sharma 1991 (1) CPR63(Bombay)
49 Lexman Thanappa Kotgiri v. Union of india 1998 CC 1093 (Bombay)
51 Govind Chanda Mohanty v .Director Medical and Health Services II (1992) CPJ 890
52 Consumer Unity and Trust Society, Jaipur v State of Rajasthan AIR 1995 SC 1922
53 Supra,n.35
home free of charges fall outside the expression “services” defined in section 2(1)(0) of the Consumer Protection Act.

Again the profession services rendered gratuitously by the doctor are beyond the scope of scrutiny of the consumer courts. 54 The questions whether the patients of “paying ward” in Government hospital are availing of medical services for consideration was the subject matter of scrutiny before the National Commission in Consumer Unity and Trust Society v. State of Rajasthan. 55 It was held that with regard to “paying wards” the payments are specially related to special rooms or beds, and the medical facilities available in a Government hospital are common to all patients inclusive of those in the pay wards, without any discrimination, even the donation collected from the patient cannot be treated as consideration for professional services rendered by the doctor. 56

The question whether contribution to Central Government Health Scheme can be considered as consideration for medical service is settled by the National Commission. 57 In this case, court confirmed that a Government servant under the Central Government Health Scheme is not a “consumer” within the meaning of section 2 (1) (d) of the Consumer Protection Act 1986. The service rendered under CGHA does not constitute ‘service’ as defined under sec: 2 (1) (0) of the said Act. The payment of a token amount for registration or token contribution made cannot be classified as “consideration” for availing of the services falling within the ambit of services under sec 2(1)(0) of the Consumer Protection Act 1986. The question whether payment of tax is consideration for medical service available in a Government hospital was raised before National Commission, 58 which has laid down that taxes levied compulsorily by the State and paid by the citizen can never

54 Harbhayan Snigh v. Daymand Medical College 1994(1) CPR 518 (Bombay)
55 Supra n.52
56 C.V. Madhusudhana v. Director, Jayadeva Institute of Cardiology 11(1992) CPJ 519
57 Additional Director, CGMS, Pune v. Dr. R.L. Bhatanaik 1996(1) CPR 136 (NC)
58 Ibid.
acquire the character of consideration for medical service provided free of change in Government hospitals.

According to the decision of the Apex Court, service rendered by a medical practitioner or hospital or nursing home cannot be regarded as service rendered free of charge, if the person availing of the service has taken as insurance policy for medical care where the charges will be reimbursed by the insurance company. Similarly, where, as a part of the condition of service, the employer bears the expenses of medical treatment of an employee and his dependant, would not be considered free of charge. So in short the service rendered by a medical practitioner attached to Government hospital, non-government hospital or nursing home or health centre or dispensary where such service are rendered free of change to everybody, would not be service under sec 2(1) of the Consumer Protection Act.

b. What Does not amount to Free Services

There are some services that cannot be considered as free services. What does not amount to free services? The complainant was operated upon, by the opposite party, in which a foreign body was left in the abdomen. He files a complaint alleging negligence. The opposite party contended that no fee was charged for the operation and only payment was recorded for medicine and operation theatre charges. It was held that the evidence of the opposite party itself would go to show that he had received a sum Rs.1,000 towards supply of medicines, operation theatre charges and rooms rent. This also proves that the services rendered by the opposite party to the complainant were not completely free of charges, and some services were for consideration. The commission followed the principles laid down in V.P. Shantha’s case and held that, the services rendered by the opposite party were for consideration and so the

59 Supra, n.35
60 Rohini Pritum Kabadi v. Dr. R.T Kulkarni 111(1996) CPJ 441
61 Supra, n. 35
complainant is a ‘consumer’ under the provisions of the Act. 62 However, in this case, the complainants have nowhere stated in the complaint that they had paid any charges to respondent doctors of the hospital. The Commission, therefore, held that the services rendered by doctor were free of charge, if that is so, it will not be ‘services’ ‘within’ the meaning of section 2 (1) (0) of the Act. 63 Another aspect is status of Government servant contributing to the medical fund.

**c. Status of Government Servant Contributing to the Medical Fund**

It is clearly held that64 so far as the special benefit and failing of supply of free medicine to a retired government servant (pensioner) in concerned, the regular monthly contribution made by him, while in service, does contribute a consideration for the service to be rendered after his retirement, by way of supply of medicine free of charge which is needed by him in connection with his treatment whether as an outdoor patient or an indoor patient. An employee or the employer registered under ESI scheme is consumer. These are some of the situations where the court awarded compensation to the patient under Government service.

Accordingly, the professional services rendered by the doctor in government hospital are free of cost and beyond the scope of Consumer Protection Act. Another exempted category of services is personal services.

**d. Personal Services**

The term “Personal Services” has not been defined under the Act, it is a question of fact to be decided by the circumstances of the case. The greater the amount of direct contact exercised over the person rendering the service by the person contracting for them, the stronger the grounds for holding it to be a contract of services, and similarly the greater the probability that the services

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62 Ibid.
64 Treasury Officer and Other Member Secretary, Pensioner Medical Fund and other v G.K. Joshi (1996) CPJ (p.22)
rendered are of the nature of professional services and that the contract is one for service. The contract of personal service and contract for personal service are to be examined in detail for this purpose.

e. Meaning of contract for personal service distinguished from contract of personal service

A contract for service implies a contract whereby one party undertakes to render services by professional or technical services to or for another in the performance of which he is not subject to detailed direction and control but exercises professional or technical skill and uses his own knowledge and discretion. A ‘contract of service’ implies relationship of master and servant and involves an obligation to obey order in the work to be performed and to its mode and manner of performance.

The parliamentary draftsman was aware of this well accepted distinction between “contract of service” and “contract for services” and has deliberately used the expression “contract of services” instead of the expression “contract for services” in the exclusionary part of the definition of ‘services’ in the section 2(1)(0). The expression “contract of personal service” in the exclusionary part of section 2 (1) (0) must, therefore, be constructed as excluding the services rendered by the employee to his employer under the contract of personal service from the ambit of the expression ‘services’. It is no doubt 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. If there is no relationship of master and servant between the doctors and the patient the contract between the medical practitioners and his patient cannot be treated as a contract of personal services but is a contract for services and the services rendered by the medical practitioner to his patient under a contract is not covered by the exclusionary part of the definition of ‘service’ contained in section2 (1) (0) of the Act.

The expression “contract of personal services” in section2(1)(0) of CPA can be confined to contract for employment of domestic servants only and the said
expression would not include the employment of medical officers for the purpose of rendering medical service to the employer. Accordingly, the services rendered by a medical officers to his employer under the contract of employment would be outside the purview of “services” as defined in section 2(1) (0) of the Consumer Protection Act.

In *Mumbai Grahak Panchayat*, the case State Commission, Bombay did not award any compensation against the anesthetist because there was no ‘Privity of Contract’ between the patient and the anesthetist whose service was hired by the surgeon for the patient. On appeal, it was held by the National Commission that the anesthetist who participated in the process of delivery of medical services to the beneficiary is as much liable as the main surgeon if negligence is established, and the privity of contract need not be established for a claim to be made under Consumer Protection Act, so long as there is hiring or availing of services for consideration.

The next aspect is the law relating to status of the patient as a consumer. The ‘services’ rendered by private medical practitioner and private nursing homes and hospitals, government hospitals, health centers and dispensaries, if not free are covered within the definition of ‘services’ and the person who avails the said services is a consumer.

**f. Patient is a Consumer**

The activity of providing medical assistance for payment carried on by hospitals and members of medical profession falls within the scope of services as defined under section 2 (1) (0) of the Act and the persons who avail such services is a consumer under the Act. Consumer includes the legal representatives of deceased consumer.

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65 1996 (1) CPR 137 NC.
66 *Cosmopolitan Hospital & Others v. Vasatha P.Nair* (1) (1992) CPJ 302 (NC)
g. Patients of Minors as Consumers

Patients of minor are consumers within the meaning of the term consumer as defined in the Act. The definition of the term consumer is wide enough to include not only the person who hires the services but also the beneficiary of such services. Thus, both the parents of the child as well as the child would be consumer within the meaning of services section 2 (1)(d) of the Act and they can claim compensation under the Act. 67 For the purpose of the effective analysis of consumer liability there should be necessarily some references to deficiency of service.

h. Deficiency

According to section 2 (1) (g), deficiency means any fault, imperfection, short coming or inadequacy in the quality, nature and manner of performance which is required to be the promotion of the legislative purpose underlying the statute to give an extended purpose to the expression ‘consumer’, defined in section 2(1) (d) of the Act so as to include legal representative of deceased consumer.

i. Meaning of Deficiency in Medical Services

The Supreme Court, in a landmark judgment given on November 13, 1995, in the case of Indian Medical Association v V-P Shanta 68 held that patients, who received deficient services from the medical professionals and hospitals, were entitled to claim damages under the Consumer Protection Act 1986.

Before the Consumer Protection Act, 1986 came into existence the term ‘negligence’ was used for dealing with failure or misdeeds of the doctors. In the Consumer Protection Act the term ‘deficiency’ has been introduced and defined under Section 2 (1) (g).

67 M/s Spring Meadows Hospitals & others v Harjot Ahlawalia through K S Ahlawalia &Anr, 111 (1998) CPJ.

68 (1995) CPJ 1 SCC
Medical Professionals are expected to exercise or provide reasonable degree of care in treating patients. A medical man rendering professional service for consideration is liable under the consumer Forum, if he falls short of the standard of reasonably skilled medical person in the field. The court did not accept the submission that deficiency in service rendered by medical practitioner could not be judged on the basis of any fixed norms and hence would not be covered under the Consumer Protection Act.69

The remedy for negligence differs from deficiency. A complainant can get compensation for loss or injury only in the case of negligence under section 14 (1) (d) of the Act. It indicates that compensation is to be awarded for the loss or injury suffered by the consumer due to negligence of opposite party. The other reliefs under the CPA can only be granted in the case of deficiency, such as removal from service, refund of charge and provision of costs.

The word negligence has not been defined in the Consumer Protection Act, but it has been indicated in Section 14 (1) (d) of the Act. The Haryana High Court has observed that the deficiency under CPA undoubtedly includes, what is negligence in the law of torts, but it is some what understood that, in all cases of negligence, there will be deficiency, but in all cases of deficiency, negligence will not be present. Deficiency may be the result of inability and lack of competence whereas negligence would be caused by carelessness and indifference. There are some instances of new interpretation to the word “deficiency”. The following are the discussion relating to that.

The State Commission, Bombay awarded compensation of Rs. 2 lakhs against a surgeon whose indifferent attitude to the patient during post-operational complications caused serious mental, physical distress to the patients who was operated for coronary artery bypass graft surgery in a Bombay Hospital. However, the National Commission reversed the decision of Bombay State Commission by holding that the private doctor who performed the operation free of charge in the

69 Renu Sobti, Medical Services and Consumer Protection in India, New Century Publication Delhi, 2001, p.25.
hospital, would not be expected to undertake and provide post-operative care and treatment to the hospital’s patient. Where the operations are performed in a Hospital, ie, an institution, it is the duty of the institution to render post operative care and treatment. The State Commission, Delhi by its majority judgment held the hospital exclusively responsible for the negligence by not providing the required Intensive Care Unit facilities to the patient and directed the hospital to pay compensation of Rs.1lakhs.\textsuperscript{70} It said that the surgeon and the hospital authority were liable for deficiency in services rendered to the patient who expired while undergoing treatment. The decision of National Commission was also upheld by the Supreme Court\textsuperscript{71}. The National Commission\textsuperscript{72} affirmed the decision of the Madras State Commission which laid down that the hospital authorities could be made liable to the patient for injury caused to him by the negligence or other fault of the doctors, surgeon, nurses, anesthetist and other members of the hospital in the course of their work.

The State Commission, Gujarat held that individual doctors are liable for negligence in performing operations of the neck of the patient in a nursing home. Similarly, the State Commission, Chandigarh\textsuperscript{73} held that the doctor is responsible for deficiency in service, when the patient suffered cerebral palsy consequent upon injection administered by the doctor. It was held by the National Commission\textsuperscript{74} that the act of carrying out the operation of the patient with rare blood group and morbid obesity, for “uterine fitromyometosis,” without making arrangement for blood and artificial respirator, by prolonging the duration of operation upto seven hours, and by shifting the patient to well-equipped hospital for monetary gain, amount to deficiency in services on the part of the attending doctor. Similarly, the fact of leaving critically ill patient under the care of

\begin{itemize}
  \item \textit{Sr. Ganagan Rani Hospitals v. D.P. Bhan} 1994 (1) CPR.P.156.
  \item \textit{Supra}, n. 35
  \item \textit{R Gopinathan v. Eskeyee Medical Foundation} 1993(1) CPR 456 (Mad) affirmed by (1994) CPJ 147 (NC):1994(2) CPR 488 (NC); (1994) 2CPJ 97 (CP) (NCDRC)
  \item \textit{Bhavu Chandhbai Majibhai Lakhani v. Bhapendra P. Sugar} 1(1994) CPJ 361 (Gang)
  \item \textit{Dr. Mrs. Reshmi B. Fadnavis v. Mumbai Grahak Panchayt} 111 (1998) CPJ 21 (NC)
\end{itemize}
unqualified compounders, particularly when the situation demands constant monitoring of the patient, amounts to deficiency in service on the part of the doctor. Whenever sample is taken for any laboratory test and charges for test are collected, it is implied that delivery of test report will be completion of “service” for charges paid. When samples were collected two times for biopsy and the samples got spoiled because of the delay in sending the same to the laboratory, it amounted to deficiency in service which was attributed to the hospital authority.

The National Commission also held one dentist negligent for preparing and supplying defective dentures to the patients. The National Commission held the hospital authority vicariously liable for negligence of the doctor whose deficiency of service caused the death of the mother and baby in a case of high risk pregnancy. The Supreme Court upheld the decision of National Commission. The State Commission, Delhi held the Blood Bank was liable for supplying contaminated blood to the patient causing viral Hepatitis-B. It was held by the State Commission, Bombay that the defendant hospital was liable for deficiency of service in post operational care to the patient. Similarly, the State Commission: Orissa held that there was deficiency in service on the part of the nursing home for admitting and continuing the treatment of a patient who required sophisticated treatment of Medical College Hospital, but this decision was set aside by National Commission on appeal.

The National Commission held that failure on the part of the hospital authority to accede to the request of the complainant to furnish all the paper

75 Pravinbhai Khuchandhhai Soni v. Dr. Rajenda R. Shah 1997(3) CPR 224 (Gug)
76 Majo Hospital v. Suni Tiwari 1997(3) CPR 574 Bhopal
77 Dr. Sr. Louie v. Smt Knnolit Fathumma 1993(1) CPR 422 (NC);1(1993) CPJ 30 (NC); (1993), CPJ 32 (NCDRC)
78 Indian Medical Association v. V.P. Shantha AIR 1996 SC 55D
79 Haresh Kumar v. Sunil Blood Bank 1 (1991) CPJ 645 (Del)
80 Arvind Kumar Himaltal Shah represented by L Rs v. Bombay Hospital Trust 1992 (2) CPR 154 (BOM)
81 Poona Medical Foundation Ruby Hall Clinic v. Maratiro Titkare 1 (1995) CPJ 232 (NC):
relating to his operation and treatment, cannot amount to ‘deficiency in service’ within the meaning of the expression used in the Consumer Protection Act 1986. A similar view was expressed by State Commission Tamil Nadu\textsuperscript{82}, in that, non-supply of case-sheets regarding the details of treatment of the complainant would not amount to deficiency in service, and the non production of the case papers and treatment sheets of the patient cannot be considered as lack of standard care and treatment to the patient. \textsuperscript{83} The hospital authority is not liable for deficiency in service for asking the patient’s relatives to settle the bills before signing the dead body form of the hospital. \textsuperscript{84} As the result of incorporation of medical profession under consumer law, the following changes have occurred.

\textbf{j. Change in Doctor-Patient Relationship}

The patient –doctor relationship is central to the patient satisfaction and to positive health outcome. The most crucial healing element is not medicine or surgery, but a patient-doctor relationship which provides hope, confidence and a healthy environment.\textsuperscript{85} Effective communication between the doctor and the patient is a contractual clinical function. The relationship between the patient and the doctor should be based, primarily on faith, confidence and holistic approach.

Thus the consumer movement in the health care sector in India is, therefore, at the crossroads. As a result, on one hand public awareness has been increasing, while on the other, the standard of health care delivery has been deteriorating. The situation is complex in our country due to different disciplines of medicine which have been traditionally and historically practiced here. Regulations of different discipline of medicines are very important. However, this aspect has remained neglected over the years. A plethora of medical colleges,

\textsuperscript{82} T. Rama Rao v. Vijaya Hospital 1997 (3) CPR 477 (Chennai)

\textsuperscript{83} Kanaiyalal Ramanlal Trivedi v. Dr. Satyanarayan Vishwakarma 1996 (3) CPR 24 (Guj); (1997) CPJ 332 (Guj); 1998 CPJ 690 (GUJ)

\textsuperscript{84} Mrs. Usha Mehrodra v. Apollo Hospitals Enterprises Ltd. 1999 (2) CPR 453(Chennai)

mostly, ill-equipped and started on capitation fee has created problem in this area. The consumer is caught in a trap. On the other, he has to face a grim health situation and the maladies arising out of it.

With the emergence of major private hospitals and private nursing homes, the doctor no longer belonged to the patient: but belonged to the institution, with materialism replacing moral and spiritual values, the system of corruption and commission, by and large, governs the medical profession. Today, that divine relationship has undergone a change to that of mostly mature relationship. The doctor offers services, the patient is a consumer and so, if there is any short fall in the services being offered, the doctor should be held responsible for his own shortcomings.

But in the case of Government hospitals, it is difficult to get proper care and attention because demand is more than supply as often the doctors make it known to the patient that he should seek an appointment at their private clinic if he is interested in speedy recovery.

Thus, medical profession which used to be a personal equation between the doctor and patient has become a high-tech profession often devoid of human touch. The shift from holistic health care to health care business is evidently clear. Another change is change in the quality of service

**ii. Change in Quality of Service**

The quality of service in patient centered approach is critical to the delivery of high quality medical services. For that purpose, quality must be defined by the patient not by the technical standard of service providers. Consumer is the king. So consumer must evaluate service quality by mentally

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88 Ibid.

89 Ibid.
comprehending their perception of delivered services with their expectation of services. ⁹⁰

Kenneth ⁹¹ defined the quality from a service marketing perspective as the difference between patient’s expectations prior to the service encounter and their perception of the service received. Clients will be dissatisfied with a service experience if it does not meet their expectations. Hence, patient’s expectation of service quality is evaluated by patient. Customers evaluate service quality by mentally comprising their perception of delivered services with their expectation. ⁹² Where there is a discrepancy between customer’s expectations and management understands of customer expectation the preferred service quality suffers. Quality of care has become an essential issue to marketing of health care services. However, quality of care is difficult to define and even harder to measure.

Taylon and Cronin ⁹³ viewed quality as a judgment concept. According to them “the real operational definition of quality is based on values and perception or attitude”. Thus, quality can be described as meeting or exceeding customer’s expectation. Today the court evaluates the things in terms of rupees.

Hospitals are also acknowledging that patient’s satisfaction is of fundamental importance as measure of quality of service. Thus, a multidimensional approach to measure healthcare quality focus on access, image of health care and patient’s satisfaction and out of that, patient’s perception of health care and their satisfaction are the most important. Quality is a

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⁹⁰ Berry,L.L.A Parasuraman and V.A.Zeithan, Service-Quality Puzzle, Business Horizon, 2000, September –October.


⁹² Ibid.

multidimensional construct and patient satisfaction is the most important dimension.\textsuperscript{94}

\textbf{iii. Patient Satisfaction}

Satisfaction is largely the result of fulfilled expectations of values. Turner and Louis \textsuperscript{95} were of the view that satisfaction is a function of the perceived discrepancy of what an individual desire’s is and what he or she actually experiences as a proportion of their desires. Desire was defined as expectations.

Accordingly to Woodside \textsuperscript{96} patient’s perception of service quality positively influences patient satisfaction, which in turn positively influences the patient, is decision to choose a specific health care provider. They define patient satisfaction as a special form of consumer attitude, ie, it as a post – experience phenomenon reflecting how much a patient likes or dislikes the service.

According to Fisk, satisfaction results when service experience meets consumer expectations. Stimson and Webb \textsuperscript{97} advocated that patient satisfaction was a short judgment of a service encounter and was determined by measuring the gap between patients perception of performance relating to their expectations. Thus, patient satisfaction is the result of fulfilled expectations of patients, which depends upon patient’s perception of medical services received and the extent to which services received meets their expectations. The ultimate result of consumer liability is patient –centered approach.

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\textsuperscript{94} Turner, Paul Dans G Louis, Beyond Patient Satisfaction, \textit{Journals of Health Care Marketing}, 2000, Vol.15, November 3\textsuperscript{rd}, pp. 47-51
\textsuperscript{95} Ibid.
\textsuperscript{96} Woodside, et at, opcit.
\textsuperscript{97} Stimson and Webb, on going to see the Doctor, \textit{Journals of Health Care Marketing} 2002, Vol.3, January 3\textsuperscript{rd} pp. 31-41.
\end{flushright}
iv. Patient-centered Approach

This approach encourages doctors to include patients as ‘partners’ in health care process. It encourages patients to ask questions, to seek a second opinion; and to share responsibility for medical decision. This approach requires effective doctors-patient communication. The doctor patient communication has been described as an integral component of quality medical care. This approach requires that information should be formal, honest, decent and truthful. Medical Audit can prevent some of the problems relating to the consumer liability of hospital authorities.

v. 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 administrators) supervised by a peer group. It facilitates self-assessment, by looking at current medical practice, comparing them with set standards of medical care and suggestion for implementation and improvement. It helps reduce deficiency in medical services, to improve attitude, skill and knowledge of the providers and to ensure collective responsibilities 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 deficiency and deviation from accepted standards.

Medical audit involves audit of structure, process, outcome, patient satisfaction and cost. An effective medical audit system for improving health care

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facilities should have performance parameter. The medical audit should help to improve their communication, identify needs for revision of policies and procedures and reassess equipments, personal and other aspects of patient care. So medical audit system is highly necessary in the new consumer world to avoid some problems relating to quality of health service. These are the main changes under Indian scenario. Insurance liability, Enterprise liability, Agency liability and Product liabilities are integral part of consumer liability. Each liability is discussed in detail as follows.

1V. Insurance Liability

Insurance liability has some developed jurisprudence in America than any other country. For the convenience of study it is better to discuss American position first.

A. Position in America

Since the 1970s many professional liability insurance policies have been written on a claims- made basis, which means that a policy purchased for a specific year cover only the claims that are made during that year that arise from incidents after a retroactive date specified in the policy. Thus, to have coverage for future claims, an additional policy needs to be purchased. This can be a renewal policy with a retroactive date covering incidents in the prior period, or it can be a reporting endorsement, often called a “tail” policy which covers future claims arising from incidents during the period covered by the prior policy without covering any new incidents.

Sometimes when providers elect not to buy tail coverage, before expiration of the old policy, they send the insurer list of all the potential claims of which they are aware so that a “claim” will be made during the policy period. In 1992, the New Hampshire Supreme Court ruled that these were valid claims triggering coverage. It was not necessary for the claims to come from the patient. Another aspect is institutional coverage.

a. Institutional Coverage

Hospitals and other employers frequently provide insurance coverage for their employees. Usually this coverage does not apply to activities outside the scope of employment. Sometimes this coverage is required by statute. Sometimes it is the result of collective bargaining or individual contracts with employees. It is a voluntary benefit provided by the employer.

Hospitals sometimes offer malpractice coverage for non employee physicians. There has been question whether this was permitted under federal law. In some contexts, it is possible that providing free coverage would violate either the stark law or the Medicare anti kickback law. An Advisory opinion issued by the HHS Inspector General in 2004 approved a proposal to subsidize the malpractice insurance for four community obstetricians. The analysis concluded that the arrangement would potentially violate the anti kickback law if there were the requisite intent, but the OIG elected not to enforce the law in the case. The analysis depended in large part on the fact that the proposal almost fit into the safe harbour for subsides of obstetrical malpractice coverage for those providing primary care in health professional shortage areas. Thus, it does not appear to signal receptivity to malpractice premium subsidies. Joint undertaking association is another unit of Insurance organisation.

b. Joint Undertaking Association

Some states have created agencies sometimes called joint underwriting associations that will sell insurance coverage to providers when the commercial market does not offer coverage. Punitive damage is also covered by the Insurance law.

105 42. C.F.R. §1001.952 (o)
c. Punitive Damages

States disagree on whether punitive damages may be covered by insurance. Some States permit coverage. While others forbid coverage, some states permit coverage for some types of punitive damages, but not others. For example, in 2001, an Ohio appellate court ruled that insurance could not cover punitive damages that were awarded upon a finding of malicious, willful, or international conduct but that the insurance company had to pay statutory punitive damages that were not based on proof of this type of conduct.\(^\text{106}\) Manufacturer programme is another feature of Insurance law.

d. Manufacture Programmes

Faced with the reluctance of physicians to prescribe drugs that frequently lead to litigation, manufacturers have occasionally adopted special programmes where they agreed to pay the legal costs and settlement or verdicts against physicians sued for prescribing the drugs.\(^\text{107}\) However, these programs predated the HHS OIG focus on malpractice subsidies as kickback. It is not clear whether these programmes would be permitted today. Availability of malpractice insurance provided easy access to insurance remedy.

e. Availability of Malpractice Insurance

The initial concern about the large number of malpractice claims and the size of the awards was that it would affect availability of medical care forcing physicians to practice defensive medicine. Another major concern has been the effect of such awards on the availability of affordable malpractice insurance to health care professionals, particularly the physician. As successful claims


increased, many malpractice insurances suffered severe losses and either withdrew from the market or increased their premium dramatically.\textsuperscript{108}

The medical community (the others to whom the losses have shifted) also responded. One approach has been to attack the legislation on constitutional grounds. In Meier, a physician challenged the Pennsylvania tort reform scheme by both limiting the liability of the insurer and reallocating the losses specifically. The act required health care providers to constitute a fund from which victims of malpractice could collect their awards this will help them to ensure adequate compensation. The Act was constitutionally challenged on the basis that the right to practice one’s profession is protected by both the due process and the equal protection clauses of the fourteenth amendment. Such legislation was alleged to have potential economic effect on that right. The court held that the right at issue was not a fundamental right explicitly or implicitly granted by the Constitution, and therefore not worthy of special protection. Therefore, any challenge to the law would be subject to the rational basis standard, and the law would stand if there were a rational basis for concluding that the law serves a legitimate government interest. In saying that the law was unconstitutional, the court noted that the “State has a legitimate State interest in regarding the practice of medicine and assuring the availability of medical malpractice insurance, and can enact non arbitrary legislation to that end without violating substantive due process.”\textsuperscript{109}

The Meier Court also rejected the defendant’s equal protection challenge alleging that the Act was underinclusive as it targeted only medical doctors and not other professionals such as Chiropractors. It also rejected the argument that the law was over inclusive as it required all doctors to pay into the fund regardless of their past history. These visions were held to be rationally related to the goals of the Act which was to increase the availability of malpractice insurance. The “rational basis” standard makes it difficult to challenge such legislation on Constitutional grounds. The other aspect is insurer’s duty to defend and indemnify and settle.

\textsuperscript{108} \textit{Meier v. Anderson} 696 A.2d 14.16 (NJ 1997)

\textsuperscript{109} Ibid.
f. Insurer’s duty to Defend, Indemnify and Settle

The insurance duty to defend, indemnify and even settle (if practical) is important both to the interests of the professional, who may be liable for a substantial award, and to the injured party, who seeks just and timely compensation. The obligation of an insurer to defend its insured is broader than the duty to indemnify.

Again in *Synder v. National Union Fire Insurance Co.*, the court held that “plaintiff need merely to show that her complaints brings the claim within the coverage of the policy”. The pleading must allege action and injury that are within the terms of the policy. The duty to defend arises whether or not ultimate liability will be proved. A North Californian Court referred to this as the “comparison test”, which involves comparing the allegations of the complaint side-by side with the particular terms of the policy to determine if the duty to defend arises, If so, the insurance company is obligated to provide a defense regardless of the ultimate disposition of the case.

Indemnification, however is another story, whether the insurer must pay on a claim will depend upon the liability of the end, if exclusion applies, upon whether the findings by the court bring the case within the policy’s exclusions. In Snyder, the plaintiff was required to show both (a) that there was no intent to cause injury and (b) that the injury did not arise from the criminal acts of alleged sexual abuse. If the injury did result from criminal acts, the insurer would be entitled to disclaim coverage under the policy.

The aspect is whether an insurance company defending or settling claims against its insured, it owes “a duty to act in good faith and without negligence.” In *Brown v. Guarantee*, the court suggested several factors to aid in a

111 Ibid.
113 155 Cal. App.2d 679 (1957)
determination of “bad faith”, although such factors may of course vary among courts. These include,

1. “the strength of the insured claimant’s case on the issue of liability and damages.
2. attempts by the insurer to induce the insured to attribute to a settlement:
3. failure of the insurer to properly investigate the circumstances so as to ascertain the evidence against the insured;
4. The insurer’s rejection of advice of its own attorney or agents;
5. failure of the insurer to inform the insured of a compromise offers;
6. The amount of financial risk to which each party is exposed in the event of a refusal to settle;
7. The fault of the insured in inducing the insurer’s rejection of a compromise offer by misleading it as to the facts;
8. Any other factors tending to establish or negate bad faith on the part of the insurer”.

The insurer also has a duty to keep the physician informed of all settlement, negotiations, and to act in good faith without negligence in efforts to effect settlement. This duty remains in effect whether or not the insured is willing to consent to any settlement. 114 Screening of spurious claims is necessary part of insurance litigation.

**g. Screening of Spurious Claims**

Another legislative response to the rising number of malpractice has been establishing, mechanism for screening spurious claims. The goal of such legislation is to increase the availability of malpractice insurance and health care by discouraging unwanted claims, and to avoid the expense of frivolous litigation which wastes judicial and medical resources. The claims are screened to litigation

by expert panel or by a judicial tribunal. The findings of such a panel or tribunal are used to evaluate the merit of the cause, and may be admissible in the litigation\textsuperscript{115} which follows.

An alternative to screening panels used in some courts is the “Certificate of Merit” requirement. Such legislation typically requires that the plaintiff’s attorney certify that he has consulted with a knowledgeable health professional in the same especially as it is the defendant who has reviewed the case and issued a written report. The health professional must conclude that there are reasonable grounds for filing the action, and the request must be filed with an affidavit or certification by plaintiff’s attorney. Some courts have held such legislation to be constitutional, while others have held that it constitutionally delegates judicial power to non-judicial person, in derogation of separation of powers doctrine. Arbitration is another method of remedy under Insurance law.

\textbf{h. Arbitration}

Another constitutionally sound avenue for determining litigation is an agreement to attribute decision (the decision to arbitrate may, of course, be made voluntarily by both parties at the time of litigation). In \textit{Morris v. Metriyakool},\textsuperscript{116} a patient was offered an arbitration option on her admission form at the time she entered the hospital. The form complied with Michigan law which required that the option be stated on the form in large, bold face type immediately above the patient’s signature. It had to be clear that the arbitration provision was optional and further, it has to be revocable within sixty (60) days after the patients discharge. The court held that the Michigan law which provided arbitration by a three member panels “did not deprive patients of a fair and impartial decision in violation of their due process rights”. Furthermore, such agreements did not constitute contracts of adhesion.

\textsuperscript{115} \textit{Blood v. Lea} U S (1985) 753 762
\textsuperscript{116} U S R. (1984) 2 188
i. Caps on Malpractice Awards

Another legislative tool used to respond to the large number of malpractice cases and the rise in health care costs is statutory caps on damages awarded by the courts. In some cases overall caps were imposed; in others only certain types of damages such as noneconomic loss/recovery are limited. Other legislation, such as allowing installment payments on future damages, has been enacted to regulate the manner in which damages are paid. In *Etheridge v. Medical Centre Hospitals*, the jury returned a verdict to the amount of $2,750,000 against two defendants whose negligence resulted in brain damages and paralysis of the plaintiff. In accordance with Virginia statutory recovery limit, the trial court reduced the verdict to $750,000 and the plaintiff challenged the constitutionality of the statute. The plaintiff alleged privacy violations on the basis that the statutory cap “preordains the result of the hearing” as well as an equal protection violation as malpractice plaintiffs are treated differently from other tort victims. A separation of powers claim was also made on the basis that caps serve to interfere “with the power of the court to enforce its own judgments.” The court rejected all such claims holding that the statutory scheme was a reasonable exercise of legislative goals.

Limitations on damages awards have also been claimed to compromise the plaintiff’s right to trial by jury. This approach has also not been very successful. As explained in *Adams v. Children’s Mercy Hospitals*, the jury has no substantive right to determine damages, despite the fact that the primary role of the jury is fact-finding, which includes determining an assessment of damages. Nevertheless, it is the function of the court to apply substantive law to the fact finding process which may legitimately include the applications of damages limitations. Thus it has been held that the role of the jury is to determine or assess the damages, not to dictate the consequences of that determination.

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117 (1989) 2 U.S.R p.621
118 Ibid.
119 506 U.S.991 (1992)
120 *Etheridge v. Medical Centre Hospital* 376 S.E 2d 525 (1989)
The reasoning in Etheridge and similar opinions was criticized in *Keeton v. Mansfield obstetrics and Gynacology*,\(^{121}\) Keeton questioned the rationale that controlling the cost of malpractice insurance would promote the availability of health care services. The court held that the legislative goal was to shift the risk of medical malpractice from the provider to the patient (who is least able to afford it) by limiting the patient’s ability to obtain full compensation for the negligence. Keeton agreed that the measures were not unconstitutional. Insurance rate freeze and malpractice premium is a statutory mechanism.

### j. Statutory Rate Freeze and Malpractice Premiums

A final method of addressing the malpractice insurance crisis has been through direct control or restriction of rate increases on malpractice premiums. In *Medical Malpractice joint underwriting Association of Rhode Island v. Paradise*,\(^{122}\) the federal district court held that such restrictions of rate increases violate the ‘taking clause” of the fifth amendment, as property of the insurance industry was taken without just compensation. Evidence of this taking was held to be in terms of the accrued deficit that the underwriting fund would incur.

Furthermore, the court found that the recoupment methods outlined by the legislature did not allow adequate compensations for the insurers. Thus, at least in that case, the legislative freeze on insurance rates carried the concept of “reform” too far and was held to be unconstitutional. Counter suit is the facility provided to doctors to identify malpractice suit.

### l. Counter Suits

In Medical malpractice, the counter suit is an action brought by the physician against the patient who previously brought a malpractice suit. The countersuit typically alleges that the malpractice action was brought in bad faith upon a claim that lacked merit, and seeks damages for malicious prosecution.


abuse of process or a similar claim. In Morowitz v. Marvel 123 two physician field 
suits to collect medical fees owed to them. The patient responded with a counter 
suit for malpractice, which was subsequently withdrawn. The court held that 
although abuse of the system is certainly disfavoured, litigants with meritorious 
claims must be provided with free access to the court system. The court held that 
the physicians should prevail on a claim of malicious prosecution, four separate 
elements must also be pleaded and proven: (1) the underlying suit was decided in 
physician’s favour, (2) the defendant showered malice (3) there was no probable 
causes for the underlying suit; and (4) special damages were suffered by the 
plaintiff as a result of the original suit. Special damages are there, beyond which, 
would necessarily be expected by anyone involved in a law suit. Thus even 
“professional defamatory type” damages must be expected in this type of suit, and 
therefore do not qualify as “special damages”’. This latter element, which is not 
required in most jurisdictions, may be difficult to satisfy, such difficulty proved to 
be fatal to the claim in Morowitz.

Counter suits raise another interesting dilemma. What if a physician, wary 
of a malpractice action, waits for the tort statute of limitation to expire before 
filing suit for an unpaid fee? The contract statute of limitation is generally larger 
than the tort statute, so a collective action may be instituted without fear of 
triggering a malpractice counter-claim. Three possibilities exist: (1) the collective 
action could go forward as intended with the malpractice action barred by the 
statute of limitations; (2) the malpractice action could proceed on the basis that 
instituting the contract claim implicitly waived the tort statute; or (3) the 
malpractice action would be precluded 124 except that poor delivery of medical 
care could still be defense to an action seeking to recover the fee for such care. 
These are the main factors of insurance liability in America.

123 423 A 2d 196.198 (D.C.App.1980)  
124 Berlin v. Nathan (III. App. 1978
B. Insurance Liability Position in England

Insurance liability in England is not as developed as in U.S.A. If a new drug or device is safe and effective, it should immediately be deemed “necessary” and approved for payment, if a new procedure is promising (even though unproven) for patients who seriously need help and who have no superior alternatives, it should not be denied potentially on account of inability to pay money.\(^{125}\)

Indemnity insurance occupied a significant factor of the market. Although insurances are scrutinizing their expenditure much more closely, denials of authorisation for care are still relatively uncommon.\(^{126}\) This belief is reinforced by the collective habits and customs formed in medical training. Courts further reinforce this presumption with “judge made insurance” ruling that expect prayers and physicians to provide even very high cost- relatively unproven technologies to patients who otherwise lack hope for survival. Another concept is managed care and quality assurance.

a. Managed Care and Quality Assurance

These changes induced by the prospective payment system have been paralleled by developments in the private sector that have also reduced traditional physician autonomy and established a very good hospital physician relationship. Just as the federal government’s desire to reduce medicare costs led to adoption of

\(^{125}\) 64 111 .App.3d 940 (1978)

\(^{126}\) Supra, n.15
the prospective payment system. Insurance liabilities have accelerated the transformation of health care from a purely professional undertaking to a business enterprise providing professional services. In India medical insurance is a recent development.

C. Insurance Liability Position in India

In India, Insurance law is now developed like other developing countries. Professional indemnity Insurance cover became available for doctors and medical establishments only from December, 1991. The term ‘indemnity’ means reimbursement; to compensate. The principle of indemnity is strictly observed in liability insurances. Professional Indemnity Insurance is designed to provide the insured person protection against the financial consequence of legal liability. If insured is legally liable to pay damages to others, the policy will indemnify him subject to the terms, conditions and limitations of the contract. Indemnity is also available in respect of legal costs awarded against the insured as well as legal cost and expense incurred by the insured with the written consent of the insurers in the defence of settlement claim. Insurance policies are provided by General Insurance Corporation of India to doctors and patients. So, many medi claim policies are also offered by private insurance companies. State also offered State incentive Health insurance for the betterment of patients. But in a developing country like India, heavy Insurance expense is not affordable to poor patients. So, this attempt will not provide any remedy to this issue. In the new era of commercialization of medical profession, enterprise liability has some relevant application.
V. Enterprise Liability

A. Enterprise Medical Liability and the Evolution in the America Health Care System

American Health Care System provided an environment in which health care enterprises have become increasingly documented, shifting liability from the physician to the enterprises is an increasingly possible direction for malpractice reform.  

The concept of enterprise medical liability had been quietly analysed in scholarly publications for a number of years, but the idea gained public prominence in the spring of 1993 as the Clinton administration made it a part of the proposed health care reforms. Reports circulated that the legislation would completely abolish the liability of individual physicians of medical malpractice. Common law physician liability was to be replaced by “enterprise liability” under which the statutorily defined health plans that were to provide care under the new system would bear all liability for medical malpractice. Enterprises liability had the potential simultaneously to garner individual physician’s support for the administrations broader health care reforms and for health care decision making on a business enterprise whose role was to be central in the administration’s vision of the reformed health system.

What happened next should be recorded as one of the great ironies in the history of political lobbying primarily through two of its major organizations, the

American Medical Association (AMA) and the physician Insurer Association of America (PIAA).\textsuperscript{130}

In America the physician payment reform transition period is an opportune time for congress to revisit Medicare Policy to revaluate the “reasonableness” criterion and to consider whether it may be “necessary to withhold (or decline to pay for) certain inventions that might benefit patients but simply cost too much for society to justify.\textsuperscript{131} If congress elects not to expressly reduce the broad scope of benefits reflected in the Medicare Statute and legislative history, it is inconsistent with the law HCFA to surreptitiously limit medically necessary services to beneficiaries.\textsuperscript{132} Notwithstanding the future of the Medicare programme, confidence in the administrative procedures affecting health care is essential to the long- term success of any system of health care financing in the United States.\textsuperscript{133} Enterprise liability constitute one of the main liability in America.

\textsuperscript{130} The administration’s recommendation was embodies in the proposed Health Security Act, S.1775 103\textsuperscript{rd} Cong, 1\textsuperscript{st} sess (1993). We are delighted that the same concept of enterprise liability was about to be proposed as an important component of national health care reform, although we informed the president’s Health Care Task Force of our reservations about its choice of the Untested Plan rather than the well-established hospital as the institutional candidate for this new brand of malpractice liability

\textsuperscript{131} See, Eg; Robert Pear, Changing Health Care Clinton Advisers Outline. Big shift for Malpractice, \textit{N.Y. Times}, March, 21\textsuperscript{st} 1993.

\textsuperscript{132} PIAA is the trade organization of physician- owned mutual insurance companies (bedpan mutual’s) that was formed in the 1970’s in many jurisdiction to write medical malpractice liability insurance when commercial insurers becomes reluctant or unwilling to do.

\textsuperscript{133} The Medicare part B programme is administered by “Carriers” usually private insurance companies under contracts with HCFA. See 42 U.S.C. \textsuperscript{139} (1982). However one may view the use of private insurance companies to process Medicare claims, the medical profession has no ground to complain about it now. Certainly neither the law nor the policy makers can have sympathy for the medical profession, now that their accomplice appears to have turned two faced and in some cases turned “State evidence” against
a. Enterprises Liability in America

In America PIAA was evidently concerned about the fact that if physicians were not liable for malpractice, they would no longer need liability insurance. The AMA, which had favoured malpractice reform the highly progressive California model of a fixed (250,000) ceiling on pain and suffering awards.  

The concept of enterprise liability, however, has deep and enduring intellectual roots. The basic idea of enterprise liability lies at the heart of the centuries-old doctrine of respondent’s superiority, which makes firms liable for the torts of their workers. In the field of medical malpractice, aversion of enterprise liability was proposed as a solution to the malpractice crisis of the mid-1970s under the label channeling. At the same time, other common law developments were expanding the liability of conventional hospitals. In the field of medical malpractice, a version of enterprise liability was proposed as a solution to the malpractice crisis of the mid-1970s, under the label channeling. In simple shorthand we call this cluster of approaches “enterprise medical liability” or “EML”. Thus there is an evolution of hospital liability and of hospital physician relations development that have created the condition for treating health care as an enterprise based industry and shifting tort liability to the industry’s constituent enterprises.

134  Ibid.
In contrast to the state of medical liability law fifty years ago, there are now several legal bases upon which to find hospitals liable for injuries inflicted by negligent physicians who are associated with the hospital in some capacity. If the physician is an employee, the hospital is subject to the standard rules of vicarious liability. If the physician enters into a contract with the hospital to deliver emergency care, radiology expertise or other such services offered by hospitals to patients, then the hospitals is likely to be liable for the physician’s malpractice under the doctrine of agency liability. If the physician is a surgeon, obstetrician, other specialist selected by the patient but granted admitting privilege by the hospitals, the hospital is likely to be subject to corporate liability for its own negligence if it failed to investigate properly the physician’s credentials and competence.

The present, day vicarious, agency and corporate liability theories, the malpractice of physicians and other health care personnel’s would remain a prerequisite to the imposition of liability on the hospital. In contrast to this exciting form of liability, however, hospitals under enterprises liability would be the exclusive bearers of medical liability for all malpractice claims brought by hospitalized patients-regardless of the provider’s status as employee, independent contractor, or holder of admitting privileges, and regardless of the site of the provider’s malpractice. In turn, physician would be insulated from, or at least insured against, personal liability to injured patients, in the same way as are nurses and other medical staff working for hospitals under the current legal regime.
b. The Evolution of Hospital-Physician Relation: Health Care as a Business Enterprise

Health care system has developed into a business with a trillion-dollar share of the economy. Hospital-physician relations have evolved in response. As recently as twenty years ago, enterprise liability would have radically transformed hospitals-physician relations in most hospitals.

Historically, physicians were almost completely autonomous actors, both outside and inside hospitals. It is only a slight exaggeration to say that the hospital functioned as a patient’s hotel and physician’s laboratory, exercising little control over the manner in which individual physicians practiced medicine. In the 1970s, this longstanding tradition of physician autonomy began to change but until the 1980s, the hospital-physician relationship was not altered fundamentally. Today, the prevalence of both fixed per procedure reimbursement from Medicare and “capitated” per-patient sums from private insurers have wrought a fundamental shift in hospitals’ relationship with their physicians. Modern hospitals face strong financial incentives to exercise tight control over physician treatment decisions.

The watershed event in America was Medicare’s adoption of the prospective payment system employing Diagnosis-Related Groups (DRGS). Under this new system, hospitals generally are paid a fixed fee per Medicare procedure, rather than being reimbursed on the basis of actual costs incurred.

136 Ibid.
138 Robert C. Derbyshime, Medical Ethics and Discipline, JAMA. Vol:9, 2001, pp. 60-62
Fee varies depending on which of the hundreds of DRGs such as cardiac arrest, hypertension or heart transplant applies to the patient’s condition. Although by its terms the prospective payment system governs only hospitals charges under Medicare, the system has endangered significant changes in hospitals physician relations.\textsuperscript{140} Under traditional cost-based reimbursement systems, physician decisions about the patient’s diagnosis and treatment affected the hospital’s income only indirectly, even then, the longer the stay and the more treatment provided, the greater was the hospitals income. In contrast, under the prospective reimbursement system a hospital’s income can be maximized by diagnosing a patient’s condition to fall in a comparatively high-payment DRG, by reducing the length of any given patient’s stay in the hospitals and by minimizing the medical services provided to a patient.

Under the new system, the decisions traditionally left entirely to physician’s discretion now have a more direct impact on hospital income because hospitals profit if their actual costs are lower than the amount received per DRG. The primary concerns of hospital administrators were leading them to attempt measures that restrict the freedom of physicians to make traditional “medical” decision. They incur a loss if their costs exceed the per DGR rate of payment. Hospital management now has a greater incentive than in the past to influence diagnosis, length of patient stay, and treatment protocol. Cost containment has emerged and the distinction between medical and economic concern has become greatly blurred.\textsuperscript{141} The hospital liability for medical injury is discussed below.

\textsuperscript{140} David M. Frankford, The complexity of Medicare’s Hospitals Reimbursement system: paradoxes of averaging, \textit{78 Iowa L.rew}, 1993, pp. 86-570.
\textsuperscript{141} Ibid.
c. The Rise of Hospital Liability for medical injuries

Charitable Immunity

In American health care, hospitals were almost totally immune from malpractice liability until the 1940S. In particular, non profitable hospitals enjoyed “charitable immunity” from tort suits brought by their patients. Hospitals are protected against the need to purchase insurance against liability to its own patients. Hospitals are liable for negligent treatment, although they could be held liable for negligence in carrying out the non-treatment duties they did perform. Mainly there are two types of error, one is medical error and another non medical error. Hospitals are liable for negligent treatment, although they could be held liable for negligence in carrying out the non-treatment duties. Mainly there are two types of error, one is medical error and another is administrative error. The malpractice liability on hospitals, and hospitals employing doctor’s nurses became governed by the universal tort standard of respondent superior, which assures both payment of an obligation to the person injured and gives warning that justice and the law demand the exercise of

| 143 | The leading early creating and justifying such immunity was Me Donald v. Massachusetts |
| 144 | Ibid. |
| 145 | General hospital 120 Mass 432, 434, 36 (1876) which held that a non-profit hospital was immune from liability for the potential negligence of an attending surgeon provided that hospitals administrators were not negligent in the selection of the surgeon |
| 146 | Several illustration of debatable issue is presented, in Bing, 143 N.E. 2d at 4-5. For example, giving blood transfusions to the wrong patient was labeled an “administrative”. General Hospital.120 Mass.432, 434, 36(1876), which held that a non-profit hospital was immune from liability for the potential negligence of an attending surgeon, provided that hospital administrators were not negligent in the section of the surgeon. |
| 147 | Ibid. |
Another related liability is corporate liability.

V1. Corporate Liability

Corporate liability extends the scope of a hospital’s potential liability to cover not only injuries stemming from the malpractice of physician selected by and under contract to the hospital (such as radiologists, anesthesiologists, and ER physicians) but also stemming from the malpractice of certain physician chosen by the patient (such as internists, surgeons and obstetricians). Corporate liability first emerged in the malpractice context in cases involving hospitals that had failed to check properly the credentials and qualification of physician they had accorded admitting privileges, or to monitor the subsequent quality of care provided by the physician or to suspend or revoke admitting privileges where necessary.149

In the Joint Commission on the Accreditation of Health Care Organization (JCAHCO) guidelines standard state licensing regulations and most of the hospital bylaws require hospitals to establish procedure for evaluating the qualification of physicians before granting admitting privileges and periodically to review physician’s performance to decide whether to continue the affiliation.150

Corporate liability is broader than agency liability in the sense that the hospital may be held liable even if the physician (for example, an obstetrician) was selected by the patient and practice in the hospitals as an independent

149 To some extent, this evaluation process has been facilitated by the National Data Bank from Adverse information on physician health care practitioner established under the health care quality Improvement Act, 1986. All payments made as a result of malpractice claims, all adverse licensing decisions by the state medical board.
contractor. In contrast, under a regime of agency liability the hospital is liable for the malpractice of independent contractors.

Corporate liability requires proof of the hospital’s negligence in assessing the surgeon’s competence. Finally, the impact of corporate liability malpractice litigation on internal hospital’s review procedures is potentially troubling. In order to establish the hospital’s corporate liability, plaintiff’s counsel often uses discovery to determine whether the hospital’s credentials and case review committee had previously expressed qualms about the treating physician’s abilities. It is crucial to the effective discharge of such committee responsibilities, however, that frank appraisals be elicited about the qualifications and performance of physicians under scrutiny. Thus, a major purpose of corporate liability is to give hospitals the legal and financial incentives to initiate meaningful peer review of physician’s performance. The threat of disclosure of information about peer review deliberations in corporate liability litigation might limit the capacity of peer review to accomplish this objective. Agency liability is an integral part of corporate liability.

V11. Agency Liability

The concept of agency liability was developed as a doctrine of agency and corporate liability in 1970. The vast majority of physician affiliated with hospitals—family, physicians, internists, obstetricians, surgeons and most other physicians enjoy an independent-contractor rather than an employer-employees relationship with the hospitals, even though they are designated as the institution’s medical ‘staff’. Physicians have the privilege of admitting their patients to the hospital’s beds and treatment facilities and they perform a number of administrative functions for the hospitals. Despite this relationship with hospitals, physicians are self or group-employed professionals and enterprises whose services are contracted for by the patients themselves. Consequently, there is usually no conventional basis for agency liability and the typical enterprise liability claim must rest instead on apparent or as ostensible authority.
The usual setting for such a claim is a hospital emergency room. Nurses, technicians and residents working in the ER are salaried employees of the hospitals, the hospitals is vicariously responsible for their tortious conduct. Physicians and independent contractor are also working in the ER and overseeing the staff. In this setting, courts have clearly held the hospitals (as well as the physician) liable for the physician’s malpractice notwithstanding the physician’s independent contractor status, the judicial theory of agency liability is based on “apparent authority.” So agency liability constituted the main component of medical liability. Apart from agency liability, Product liability is also an integral part of medical liability.

VIII. Product Liability

A. POSITION IN U.K

Product Liability has some application in medical negligence cases. A consumer who was injured or whose property was damaged by a product which he had brought would bring an action against the retailer for damages for breach of contract. Under the Sales of Goods Act an implied term was included in the contract to the effect that the goods will be fit for the purpose intended. However, because of the doctrine of privity of contract no action for damages could be brought by a third party even when it was foreseeable that a defective product would cause him harm, e.g.: a member of the purchaser’s family. In the landmark

151 Section 267 of the Restatement of Agency (1958) provides. One who respects that another is his servant or other govt and thereby causes a third person justifiability to rely upon the care or skill of such apparent agent is subject to liability to the third person justifiability to rely upon the care or skill of such apparent agent is subjected to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such, error but giving the wrong blood to the right patient was a “Medical” error.

case *Donoghue v. Stevenson* \(^{153}\) the House of Lords acknowledged the possibility of tort brought by the ultimate consumer against the producer, but as the difficulty of proving negligence remained, the situation of the consumer remained relatively unfavoured.

The Consumer Protection Act 1987 came into force on March 1988. The essence of the present law is that the producer of a defective product is liable for damages caused by that product, unless he can rely on one of the defences. Thus, the system focuses on the condition of the product instead of the conduct of its producer.\(^ {154}\)

The terms ‘producer’, ‘product’ and ‘defect’ are defined by the Act as well as the type of damage for which the producer may have to pay compensation. The title of the Act can be misleading however, as it will protect not only a ‘consumer’ but anyone who suffers injury or damage as a result of a defective product. The plaintiff must show (a) damage (b) defect in the product, and (c) a causal link between the two.\(^ {155}\)

The meaning of producer under this law is (a) the person who manufactured it (b) in case of substances which has not been manufactured but has been won or abstracted, the person who won or abstracted it (c) in the case of a product that has not been manufactured, won or abstracted, but whose essential characteristics are attributable to an industrial or some other process.\(^ {156}\)

A ‘product’ is ‘any goods or electricity’, the ‘goods’ include substances (natural or artificial solid, liquid or gaseous form) growing, crops things,

\(^{153}\) (1932) AC 562  
\(^{154}\) Sec1 (2) of U.K. Consumer Protection Act 1987  
\(^{155}\) Ibid.  
\(^{156}\) Sec: 45(1) Ibid
comprised in land by virtue of being attached to it, ships, aircraft and vehicles, component parts and raw products incorporated into finished products.\textsuperscript{157}

It is a defective product “if the safety of the product is not such as persons generally are entitled to expect”. The definition is not confined to or which are dangerous to health, but includes risk to property and produces damage and inconvenience. The notion of ‘defect’ in the Act leaves many questions A difficulty is that it fails to provide a readily ascertainable objective standard against which a manufacturer can ensure the safety of his product, and in that unanswered.\textsuperscript{158} Respect, does not move too far ahead from, the previous position under the law of torts.\textsuperscript{159}

The defences are found in section 4 of the Act. One is that defect is attributable to compliance with any statutory requirement or EC obligation. Also, that the person proceeded against did not at any time supply the product to another which covers causes of mistaken, identity, where the wrong manufacture or supplier is used or where the goods are stolen from the manufacturer or distributer. The third defence exculpates the manufacturer for goods supplied for non-profit reasons, eg gift, charity etc. Another important one is the “development risks” defence, which has been imported into the Act in England, whereby “the state of scientific and technical knowledge at the relevant time was not such that producers of products of the same description as the producer in question might be expected in his products while they were under his control. The nature of the

\textsuperscript{157} Stapleton, Three problems with the new Product Liability, in Cane &Stapleton (eds), Anglo- American Law Review,\textit{2000}, p. 205

\textsuperscript{158} Section 3(1) of Consumer Protection Act.

defence and its implementations in the UK has provoked controversy, and the commission has accused UK of allowing too broad a scope for the defence.

The product liability has some application in Medical Negligence case. In all personal injury cases causation is a crucial element of the plaintiff, claim, and this is no less true in product liability cases. First, there must be medical causation of the injuries claimed by a plaintiff to the danger of the product. In most cases, this will not be a problem, unless the claim involves medical conditions which arguably were not caused by the injury. In addition to that the other defences to product liability claims may be couched in term of causation. For instance, a plaintiff’s failure to adhere to instructions for using the product may be described as an intervening, new cause of the plaintiff’s injury, relieving the defendant of responsibility due to lack of causation. Misuse of a product is a defense to product liability claims, and this defense may be couched in term of causation.

As previously indicated, under both strict liability and warranty theories, a plaintiff need not prove negligence. Similarly, the defence of contributory negligence of the plaintiff, available in product liability cases founded upon negligence, is not in most jurisdictions available to a defendant in cases involving strict liability and warranty. The defense of assumption of risk may or may not be available in any or all of these theories, depending upon the rulings in particular jurisdictions.

Generally, this requirement would exclude leases or loans of products. It may also exclude products provided only incidental to a transaction in which the primary focuses is service. A seller may be anyone who sells the products or a component of the product to any other party through the distributive chain, upto

160 Ibid
and including the sale to the consumer. A manufacturer “sells” the product to a wholesaler. A manufacturer of a component part “sells” that part to the manufacturer of the product in which the component part will be incorporated. A wholesaler “sells” the product to the retailer, who in turn “sells” the product to a consumer. 161

It must be shown that the product was defective at the time it left the control of the seller. In a case against a manufacturer the time would be when the product is sold and delivered to a wholesaler. In the case of a wholesaler, that time would be when the product is sold and delivered to a retailer. With a retailer, that time could be when the product is sold and delivered to a consumer. Needless to stay, if the condition of a product is unreasonably dangerous after the product has left the control of a defendant, the defendant cannot be held liable, unless the change was reasonably foreseeable within the scope of the intended use of the product. 162 As can be seen from above discussion, modern tort law imposes liability on unreasonably dangerous and defective products. American product liability is entirely different.

B. Position in America

The important feature of negligence per se theory in this context is that it is not the equivalent of strict liability. The restatement (third) of torts: product liability, on the contract, provides that violation of a statute or regulation renders a product defective per se (perhaps best described as “strict liability per se”). 163 There is a significant difference between the foundations of negligence per se and strict liability per se theories. A traditional negligence per se theory focuses on the

161 Ibid.
162 Duncan v. Cessna Aircraft Co. 665 s.w.2d 414, 426 (Tex. 1984) (Stating that “strict liability is closely analogous to negligence per se”) Dippel v. Sciano, 155 N.W.2d 55, 64, 65
defendant’s conduct; whereas the restatement(third) strict liability per se theory ostensibly ignores conduct and focuses on the product vis-a-vis the legal requirements. The distinction is not academic, especially depending upon the jurisdiction, as some jurisdictions apply comparative fault principles to strict products liability claims based upon this analogy, while others reject any comparison to support the application of comparative fault principles to strict liability claims.\textsuperscript{164} In the case of critical situation state have adopted health care proxy statutes, which allow an individual to appoint an agent to make health care decision on behalf of the principal.\textsuperscript{165}

Supporters of health care proxy legislation argue that the appointment of a proxy avoids the problem of trying to anticipate future medical circumstances and treatment choices. Agents are asked to make contemporaneous decision, knowing the patient’s prognosis and treatment alternatives and one hopes, knowing the patients treatment decisions. In addition to making treatment decisions, the proxy can be used to authorize the agent to expend fund for medical treatment, to gain access to medical records, or to choose health care professionals. Of course the health care proxy concepts are not a panacea either. Disputes will still arise concerning the scope of the agent’s authority and whether the agent is acting in a manner consistent with the patient’s best interest. Significant dangers lurk if these legislative efforts are viewed or used as panaceas.

The statutes to provide clear and comprehensive guidelines that allow physicians to indicate further medical treatment would be helpful to particular patients. Subsequent development in America is the Medical Liability Reform Act of 1991. President has proposed the Health Care Liability Reform and Liability of

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\textsuperscript{165} S.1123, 102d Cong. 1\textsuperscript{st} sess (1991), See infra notes 375-388 and accompanying text for a discussion of the provision of the proposal
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\textsuperscript{166} The AMA “deeply appreciate” the Bush Administration Proposal and “continue to strongly support”. S.489 \textit{(American Medical Association Chicago Illionois) July 1991}
\end{flushright}
Care improvement Act ("Bush Proposal"). The objectives of both proposals, which are supported by the American Medical Association (AMA) are rooted in the medical/legal dialogue rather than in data revealing a crisis and identifying both its cause and a workable solution. The existing data counsel against enactment of the basic provision of either proposal.

State legislative action reached a turning point in 1988. Fewer States than in the peak years of 1986 and 1987 enacted tort reform legislation. In addition, most tort reform proposals considered in 1988 were coupled with extensive insurance regulation. Nonetheless, the march toward state tort reform continued. States amended or abolished the collateral source rule modified joint and several liability mandated periodic payment resolution measures. In 1990, three states enacted some tort reform measure, and four other measures in 1991.

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167 Ibid

168 Robert Lumbo (American Trial Lawyers Association director State relation) says the tort reform movement peaked b/w 1986 and 1987. When there was an identifiable crisis for a viewpoint and may states panel bills, The following are the liability under, Medical Reform Act of 1991 Liability Under Medical Reform Act of 1991

169 Minnesota enacted a provision basing liability part, on percentage of fault, MINN. STAT. ANN & 604.01 (West 1992). Florida maintained its limitation on joint and several liability by repealing a provision on that part of its general tort reform legislation modeled after the 1987 AMA proposal. FLA. STAT. ANN & 768.81 (west 1991)

170 MEDICAL MALPRACTICE, Supra note 16. Virginia enacted legislation enacting parties to elect a summary trial, VA CODE, ANN 48.01.5761 (Michie 1991). Michigan enacted a plan to provides conciliation, medication and other alternative

171 In 1990, there states legislated tort reform measures, Colorado amended its good Samaritan statute for emergency care immunity to include hospitals and now prohibits punitive damages against doctors in certain cases. Main reformed collateral source rules for medical malpractice cases, established a five year’s medical liability project to develop practice guidelines, and established a Rural Medical Access program to increase obstetrical care. Arizona limited the liability of doctors and hospitals in cases of births under emergency situations.

172 The Colorado legislate prohibited parties damages awards in cases arising from the prescription of FDA-approved drugs, the Nebraska legislative abolished joint and several liability for noneconomic damages, the Washington legislature expanded the application of North Carolina’s Good Samaritan Statute and established a pilot medication program. Id. in addition, the Governor of Colorado signed into Law the Good Samaritan measures...
The American Tort reform Association (ATRA) predicts that in the coming years, state legislatures will concentrate their efforts on narrow reforms limiting punitive damages and encouraging alternative dispute resolution.\(^{173}\)

a. The Harvard Study

In 1989, the New York Department of Health and Human Services Commissioned the Harvard Medical and Law Schools to conduct what should prove to be the most influential and controversial study of all ("the Harvard Study"). The study addresses the rate of physician negligence in New York hospitals in 1984.\(^ {174}\) The Harvard team identified cases of death and injury caused by physician negligence and concluded that approximately 12.5% of those injured asserted claims against physician or hospital.\(^ {175}\) Despite that conclusion, the Department of Health and Human Services and the New York Legislature began calling for the adoption of non-fault medical malpractice for legislation. The Harvard study then compared the incidence of negligence with the number of

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173 The emphasis in the future will be on specific narrower reforms, according to the American Tort Reform Association (ATRA). While more attention will be directed towards limiting punitive damages and to defending the tort reforms that have been achieved in recent years, innovative alternatives to traditional tort liability especially in the medical malpractice will be introduced.


175 HARDWARD STUDY, the New York Commission of Health and Human services acted this data, before the report issued to support a call for a non- fault medical malpractice liability legislation in New York, William Bunch. Furor on Malpractice, NEWS DAY Jan 30, 1990 at 21
malpractice claims made by lawsuit on written or oral demand 176 and concluded that “the number of negligent adverse events was eight times the number of tort claim.”177 History indicated that approximately one-half of all claimants were eventually compensated. Thus, the incidence of negligence is approximately sixteen times greater than the number of paid claims. 178 Strict liability is an important component of product liability.

b. **What are the Special Strict Liability Rules for Products Liability?**

The major exception to the requirement that liability be based on fault occurs when liability is based on breach of implied warranties or on strict liability in tort. In this area of the law, liability based on contract and liability based on tort overlap. The implied warranties of merchantability and fitness for a particular use are based on contract. These warranties form the basis for finding liability without fault for many of the injuries caused by the use of goods and products. Normally the seller is liable for the breach of the warranties, but in some situations persons who lease products to others have also been found liable.

Strict liability applies to injuries caused by the use of a product that is unreasonably dangerous to consumer or user and that reaches the user without substantial change from the condition in which it was sold. Usually the manufacturer or seller of the product is liable. Strict liability in tort does not require a contractual relationship between the seller and the person injured to

176 The Harvard Study defines “claim” as “a demand for tort compensation for injury and financial loss arising out of medical care”. Thus, the data reflect both suits and oral or written demands (by the patient, his or her family or attorney) to the physician, hospital, or insurer. Moreover, the data reflect these cases in which the insurer identified negligence and approaches the patient or his or her family regarding settlement

177. Ibid.

178 Ibid.
establish the liability of the seller. Some courts have extended strict liability to persons who furnish goods or products without a sale. Health care providers are generally considered to be providing services, not selling or furnishing products; health care providers who have seldom been found liable for breach of warranties or strict liability. However, plaintiffs have made numerous efforts to convince courts to apply these principles to make it easier to establish liability. These efforts have arisen out of services involving blood transfusions, drugs, radiation, and medical devices.

c. Blood Transfusions

One known risk of a blood transfusion is the transmission of diseases such as serum hepatitis. In 1954, a New York court ruled that blood transfusions were a service, not a sale, so that hospital liability for diseases conveyed by the blood could not be based on breach of warranties or strict liability. However, courts in several other States began applying these product liability principles to blood transfusions. Legislatures in many states enacted statutes intended to reverse these court decisions. Some of the statutes state that providing blood is a service, not a sale. Other statutes expressly forbid liability based on implied warranty or strict liability. The second type of statutes provided somewhat more protection because a court that chooses to ignore the public policy decisions of the legislature embodied in the first type of statutes could still impose liability on the hospitals by extending the applicability of strict liability to services.


180 E.g., Shortess v. Touro Infirmary, 508 So. 2d 938 (La. 1988) (Hospital strictly liable for blood with undetectable form of hepatitis; Cunningham v. MacNeal Mem. Hosp: 47 III. 2d 443, 266 N.E. 2d 897 (1970))

181 E.g., Weishorn v. Miles – Cutter, 721 A2d 811 (Pa. Super. Ct. 1998) (state blood shield law also protect commercial suppliers from strict liability, breach off warranty)

182 See Hoven v. Kelbe, 79 Wis. 2d 444, 256 N. W. 2d 379 (1977) (Rejecting extension of strict liability to medical services)
These statutes have been found constitutional.\textsuperscript{183} Health care providers can still be liable for negligence in administering blood transfusions. Immunity statutes in some states also apply to some other services, such as tissue transplantation. Another is application of law in case of drugs.

d. Drugs

Efforts to use implied warranties or strict liability to impose liability on hospitals for the administration of drugs have generally been unsuccessful. For example, a Texas appellate court refused to apply these product liability principles to the administration of a contaminated drug.\textsuperscript{184} In 1992, a Pennsylvania court ruled that a hospital was not a merchant when it dispensed a drug incidental to the service of healing, and it was not liable under implied warranties for an allergic reaction.\textsuperscript{185}

c. Radiation

In 1980, the Illinois Supreme Court reversed a lower court’s application of strict liability principles to X-ray treatment.\textsuperscript{186} The court ruled that the issue in the case was the decision to use a certain dosage. The X-ray themselves were not a defective product; so strict liability in torts was not applicable. Medical devices and application of product liability law are discussed below.


\textsuperscript{184} \textit{Shivers v Goodshepherd hosp.}, 427 S.W2d 104 (tex. Civ.app.1968)


e. Medical Devices

broke and remained in a patient’s body.\(^{191}\) The court viewed the hospital as merchant, not a user. Even when the health care provider is viewed as only a user, the provider may still be liable based on negligence, and the manufacturer of the equipment may be liable based on implied warranties or strict liability in tort.

The one major exception was Missouri. Missouri permitted strict liability cases against providers\(^ {192}\) until 2000, when the Missouri Supreme Court ruled that they were not permitted\(^ {193}\). Some courts may not view certain items supplied by health care providers as integral to the provider’s service. In 1981, as Texas court found that a hospital could be strictly liable for supplying a hospital gown that was not flame-resistant because it was not integrally related to supplying services.\(^ {194}\)

Some implied warranty and strict liability claims concerning medical device laws are preempted by the federal medical device laws.\(^ {195}\) In 1996, the United States Supreme Court ruled that some claims were not preempted.\(^ {196}\) In *Karibjaniam v. Thomas Jefferson University Hospital*, a widow alleged that her husband’s death was caused by an agent of the defendant hospital. The widow

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191 *Skellon v. Druid City Hosp*: Bd., 459 so.2d 818 (Ala.1984)
193 *Budding v. SSM Healthcare Sys*: 19 S.H 3d 678 (Mo.2000)
195 21 U.S.C.$360 c
196 *Medtronic Inc. v. Lohr* 518 U.S. 470 (1996) for device “substantially equivalent” to devices that preexisted MDA and exempt from the rigorous premarketing approval review. MDA does not preempt the plaintiffs state common law claims for defective design, defective manufacture, failure-to-warm and failure to comply with FDA standards. MDA may preempt state law tort claim. Claim based on state statute, regulation, but federal, state requirements must specifically apply to particular medical device, state requirement must add to or be different from federal requirement: Buckman Co. v. Plaintiff’s Legal Comm. 531 U.S. 341 (2001) (common law claims of fraud on FDA preempted by MDA. Tort claims alleging violations of FCDA preempted)
alleged that the injection should not have been administrated, that this product was inherently unsafe and that the defendant hospital knew or should have known it to be so.

The defendant hospital contended that it was not in the “business of selling” thorium dioxide and instead, merely provided its services to the widow’s descendent. The court held that as long as hospital regularly supplies such a product to its patients, the hospital was held liable.\footnote{198}{Section 402A of the Restatement (second) of Torts which states in part (1) one who sells any product in a defective condition unreasonably dangerous to the user or consumer…….. is subject to liability ….is (a) the seller in engaged in the business of selling such a product.} In \textit{Karibjanian}, the plaintiff was allowed to proceed with her claim against the hospital, and thus was given the opportunity to present evidence that the thorium dioxide came from the defendant hospital and that the hospital supplied it to plaintiff descendant and that the hospital regularly supplied this injection and product to other patients.

In most cases, prior to using or administration of potentially dangerous products, a physician has a duty to warn patients about the risks and side effect associated with the product to be used. An example of the duty of the physician to warn patients about possible risks and side effect with regard to product manufactured by the other is illustrated in \textit{Tresemer v. Barke}.\footnote{199}{(1978) 86 Cal. App.3d 656,150, Cal. Rptr.384.} In \textit{Tresemer} the plaintiff alleged that the defendant doctor breached his duty to warn her of the dangers of the Dalkon shield when, subsequent to its insertion, he obtained knowledge of the dangerous and did not notify the plaintiff. As a general rule, the defendant owes a duty of care to all persons who are foreseeably endangered by his conduct.

Again in \textit{Dillon v Legg},\footnote{200}{68 Cal.2d 728,441,P.2d. Cal.Rptr. 72 1968} the real question was whether it was the physician or the manufacturer who was responsible for providing the subsequent
information to the patient. In assessing the manufacture’s liability, courts have consistently held that the manufacturer is not liable where the physician using the manufacture’s product has been made sufficiently aware of the risks associated with the product.\textsuperscript{201}

But in \textit{Tresemer},\textsuperscript{202} it was held that it was the duty of the manufacturer to adequately warn its possible and actual dangers to the physician. It would be virtually impossible for a manufacturer to comply with the duty of direct warning, as there in no sure way to reach the patients. Once a physician is adequately informed by the manufacturer of the actual and possible dangers of a product, the physician “acts as a learned intermediary between the patient and manufacture, thus breaking the chain of liability” In \textit{Tresemer}, it was held that an action for failure to warn the patient may be maintained against the physician due to the continuing confidential relationship between the physician and patient and the fact that the danger arose from that relationship, so under Product liability, the liability is also focused on doctors.

Reform of the legislative system attempts to address several concerns in the 1990’s. One is accessibility of health care as accessibility costs of malpractice liability insurance have driven physician out of certain practice areas. The second is regarding quality of health care, physicians have been forced to practice defensive medicine, which thereby limits the overall resource for adequate care. A third is affordability. Since escalating costs of health care are inevitably passed into consumer.

Reform of the litigation system has taken the form of encouraging alternative dispute resolution including arbitration, mediation and early settlement, as well as the screening of spurious claims. A number of States have imposed limitations on contingent fee arrangements between the attorney and client so that

\begin{itemize}
\item \textsuperscript{201} \textit{Ibid.}
\item \textsuperscript{202} (1978) 86 Cal.App.3d.656,150, Cal.Rptr.384
\end{itemize}
more of the award goes to the injured plaintiff. Some states have eliminated the collateral sources rule which otherwise precludes the plaintiff from recovering from both the tort favour and a collateral sources, such as insurance. Some jurisdiction now permits allocation of liability among tort feasors and may allow claims under the theories such as enterprise liability. A number of jurisdictions have imposed damages that can be awarded. Some have attempted to abolish joint and several liabilities. Some statutes have rendered litigation by shortening the applicable statutes of limitation for medical malpractice claims.

C. Product liability position in India

In India product liability is an integral part of tortuous liability. Application of product liability is same as that of England. In India Product liability is not strictly imposed. It is a matter of concern of civil court. The delay in processing the suit can be considered as an advantage for the manufactures as they can rectify the object of the product. As an ordinary user, a person cannot establish the technical defect of the product in court so the manufactures can very well defend the suit. These are the main problems of product liability in India

Conclusion

One of the main defects of CPA is in the interpretation of medical services under the CPA, because of which the patient-doctor relationship might get adversely affected. As a result the doctor had started practicing defensive medicine which includes ordering unnecessary test and investigations. All professionals are insured for their safety thereby making the treatment costly for patient’s. As a result the Health Care Service has become Heath Care Business.

It is highly necessary to update the knowledge of doctors. Doctors should understand patient’s expectations which include immediate attention, proper diagnosis and sympathetic behavior of the doctor. Generally the doctors were not

203 Ibid.
ready to maintain even medical records. However for the enforcement of the regulating measures under CPA, medical records are highly necessary.

Another defect relates to patient’s right to quality medical care. Under consumer law there is no mechanism for enforcing quality improvement of health care institutions. So the people are exploited by the“so-called medical institutions” in the consumer world. The rendering of quality medical services are not properly channelized. An effective competent legislation is highly necessary in this area. A separate Medical Tribunal should be constituted for quality remedy through the hands of expert judges.

In India, Medical Negligence jurisprudence does not have any statutory guidelines. That is why doctrines like “accepted practice”, “Informed consent”, “Ship-Captain theory “were developed by the Court in the absence of any Law. However these doctrines must be integrated within the provisions of a new law. Medical Malpractice claims Act is the need of the time. It was aptly stated by Tindal.C.J., in Hancke v. Hooper, 204 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 case 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, the Maryland legislature adopted the Health Care Malpractice Claims Statute in 1976. This statute requires that medical malpractice litigants attempt to resolve their disputes by submitting them to an arbitration panel before resorting to court action.205 “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

204 (1835) 76 U.S.R p.8
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. India must also to take immediate steps on similar lines.