# MARKET MEDICINE AND MALPRACTICE

*Edited by*
Amar Jesani
P.C. Singhi
Padma Prakash

*Published by*
**CEHAT**
Centre for Enquiry into Health and Allied Themes, Mumbai
and
Society for Public Health Awareness and Action, Mumbai

2004

Market, Medicine and Malpractice

# MARKET, MEDICINE AND MALPRACTICE

*Edited by*
Amar Jesani
P.C. Singhi
Padma Prakash

**Centre for Enquiry into Health and Allied Themes, Mumbai**
**and**
**Society for Public Health Awareness and Action, Mumbai**

**2004**

*First Published in 1997*
*First Reprint in January 2004*
by **CEHAT & SPHAA**

**ADDRESS FOR COMMUNICATION**

**Centre for Enquiry into Health and Allied Themes**
Survey No. 2804 & 2805
Aaram Society Road,
Vakola, Santacruz (East),
Mumbai – 400 055
Tel: 022-26147727
Fax: 022-26132039
Email:cehat@vsnl.com
Website: www.cehat.org

**Society for Public Health Awareness and Action**
21, Valencia,
Juhutara Road
Santacruz (West),
Mumbai - 400 049.
Tel. : 022-26603919
26608921



ISBN 81 - 89042 - 00 -9
*Cover Design* : Pravin Sanas

*Composing and Layout* : Economic and Political Weekly, Mumbai

*Production Consultant* : A B Pujar

*Printed at* : Chintanakshar Grafics, Mumbai - 400 031.

*To those who were deceived and harmed by the medical traders, and who instead of burying their heads in sand decided to raise the banner of consumer rights.*

*To all those who are selflessly involved in providing health care to the needy and are also struggling for the universal acceptance of people's right to health care and for patients' rights.*

## ACKNOWLEDGEMENT

It is not so easy to write about one's suffering and the trauma. Three authors: P C Singhi, Raghunath Raheja and Yasmin Tavaria, lost their near and dear ones in the course of medical care. They have done a great service by sharing their experiences here in detail. Saroj Iyer's sensitive narrative of the problems of the Parabs and their comatose daughter is, to say the least, moving.

Many of the other papers have been published in various journals (or newspapers), either in the same form or have been appropriately edited here. We thank authors of these papers and editors of the journals in which these papers were published for readily granting us permission to include them in this book. They are:

*Medico Friend Circle (MFC) Bulletin*: Amar Jesani, 'Size of Private Sector in Health Care in India', No: 173-74, July-August 1991.

*Radical Journal of Health (RJH)*: Mihir Desai, 'Medical Malpractice and Law', March 1988.

*FRCH Newsletter*: N H Anita, 'Misuse of Medicine', Vol V, No 4, July-August 1991.

*The National Medical Journal of India*: Sunil Pandya, 'Rot in the Maharashtra Medical Council', Vol 6, No 2.

*The Times of India* (Bombay): S S Tinaikar, 'Medical Ethics and Patients',

*The Hindu* (Madras): M S Venkatraman, 'A Patient's Right to Know' Sunday, December 8, 1991.

*The Indian Journal of Social Work (IJSW)*: Arun Bal, 'Consumer Protection and Medical Profession', Paper at a seminar sponsored by the Medico Friends Circle (MFC) Tata Institute of Social Sciences (TISS), and Association for Consumer Action on Safety and Health (ACASH) held on August 30, 1992, at TISS, Bombay.

There are a number of individuals and groups whose help and constant encouragement made it possible for us to bring this book out. We thank all of them.

# Contents

# FOREWORD

What is ethics? Is it superior justice? Since in the legal set up justice is justice according to law, is ethics higher than legal justice? But if we consider legal justice and ethical justice as distinct and separate, the problem is not solved since what is taken as 'superior justice' is open to different interpretation depending on the values reflected in the society in general and the individuals in particular. In our society, the Constitution itself sets up the standard of values, namely, 'justice – social, economic and political'. All ethical principles designed for individual or state action in private or public life must ultimately centre around this basic value system which embodies the best of human endeavour and accomplishment.

The Lexicon of the Sydenham Society defined 'ethics, medical' as "the laws of the duties of medical men to the public, to each other and to themselves with regard to the exercise of their profession". This can well apply to lawyers. But in both cases, their role in society is heavily oriented towards public interest.

The Hippocratic Oath is said to be about 25 centuries old; however, its basic tenets remain as valid as ever. Its archaic language and formulation, however historically attractive, have become anachronistic, leading to its restatement in the Declaration of Geneva (by the World Medical Association after the second World War). Amongst the solemn pledges which a new entrant should know, the following are important:

> I solemnly pledge myself to consecrate my life to the service of humanity...
> I will practise my profession with conscience and dignity.
> The health of my patient will be my first consideration.
> I will respect the secrets which are confined in me .....
> I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient.
> I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity...

The International Code of Medical Ethics prescribes *inter alia*, the following duties:

> A doctor must practice his profession uninfluenced by motives of profit.

The following practices are deemed unethical: (a) Self advertisement. (b) Collaboration in any form of medical service in which the doctor does not have professional independence. (c) Receiving any money in connection with services rendered to a patient other than a proper professional fee, even with the knowledge of the patient.

Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest.

A doctor must always bear in mind the obligation of preserving human life.

A doctor owes to his patient complete loyalty and all resources of his science ...

A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him.

A doctor must give emergency care as a humanitarian duty.

But the more important question is how these ethical prescriptions and prohibitions are observed in day-to-day situations? Ultimately, medicine is what medicine does, just as "law is what law does". The Bar Council of India formulated certain rules relating to standards of professional conduct and etiquette. They relate to the duties of the advocate which he owes to the public, to the court, to his client, to his opposite counsel and to colleagues in the profession. But what we hear today is very depressing. A number of astonishing unethical practices are being reported daily, even at the highest levels of the legal profession – a menace, slowly but surely and perceptibly threatening the foundations of a fair and objective justice system in this country. What about medical practice? Is it in any way different?

In 1989 Dr Hiranandani wrote a strong article on 'The Kidney Traders'. He wrote, "Apparently we believe that if money is to be gained, nothing is sinful. We burn our brides, do amniocentesis to find out the sex of the unborn baby and abort it if it is going to be a girl. In such a setting doctors perhaps do not think it is unethical or cruel to rob a kidney from an unsuspecting person." He then says, "Recently, more gristly rumours (news) are making rounds: (1) kidneys removed clandestinely without the donor's knowledge; (2) donors not adequately paid; (3) Bangladeshi women lured with job offers and their kidneys are removed; (4) So called missing persons we see on TV land up in the hands of specialists, their kidneys removed and they are killed and their bodies are disposed of in Bombay's sewers." Hiranandani refers to an advertisement which appeared in the *Times of India*, May 21, 1989 by Gambro Nexin (India) Medical which said, "Once in a lifetime opportunity for dialysis patients – kidney transplants for dialysis patients on a subsidised rates". Hiranandani could not get the names of doctors who were behind this. But obviously, the advertiser was going to give kidneys on demand. The recent incidents and the cases discovered have shown that all these allegations were true. In India, it is estimated that kidney transplanting was a billion rupee industry and the beneficiaries were doctors, agents, hospitals, etc. Perhaps these doctors may justify these actions on grounds 'medical'. But what justification can there be on the ground of 'ethics' or for that matter, even in law?

Diana Brahams, the editor of *Medico-legal Journal* (London) says, "In a civilised society, no one should have to sell non-regenerative flesh or organs for his sustenance, and such contracts which are unethical and abhorrent, cannot be regarded as satisfying a valuable social purpose even though for the recipient the benefits of transplanted kidney may be considerable. Arguably, the evil in the transaction outweighs the good." Plainly, it is against public policy and illegal. Removal of a kidney is a major operation, the operation is not for the benefit of the donor and therefore, it cannot be said that the donor has consented to physical harm on himself. The result is that all persons involved in the removal of such organs can be charged for causing grievous hurt, or perhaps theft and perhaps other serious offences under the law. However, in reality, the malaise continues unchecked. It is only recently all commercial transactions pertaining to removal of organs and transplantation have been prohibited by a central statute, though not applicable to all states.

The International Code of Medical Ethics expressly says that doctors should be uninfluenced by motives of profit. That is because medical aid is a matter of service to humanity. The Hippocratic Oath says, "Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption". But as in court, so in life, the Oath has scant respect, and the profession has become a business – a trade – and the rule is to exploit and make money by means fair or foul. When a patient comes to a doctor, he suffers from more than his illness, he suffers from social dis-

advantages. He is nervous, fearful and perhaps even terrified. But he has trust. If this trust is exploited, what is left for medicare? Excessive medication, over-prescription or over-investigations, dubious nexus between the specialists and the general practitioners resulting in the patients being made to go from one specialist to the other ostensibly for investigations but really to fleece the patient! P C Singhi's case in this volume is a pathetic illustration of the pachydermic attitude of the profession. Equally exasperating is the legal proceedings in which the only question is one of assessing damages, the negligence having already been upheld by the Medical Council. Yet the case has appeared on the board 200 times, Singhi requiring to change his advocates not less than eight times!

The law gives monopoly to the lawyers through the Advocates Act and the Bar Council, and to the doctor through their Medical Councils. That is on the assumption that their role in society is heavily oriented towards the cause of public interest. If the right to life (Article 21 of the Constitution) is to have any meaning, it can only be on the basis that the right to medical care and health is guaranteed to every Indian by all those who are concerned about it. If the state denies this, he can enforce it through writs. But if the medical profession neglects, he can only thank his stars. In 1977, the World Health Assembly declared its global goal of 'Health for All by 2000 AD'. I wonder whether we are anywhere nearer to the goal by that time.

With this anthology on medical practice – and malpractice – and health care, the editors have shown how with increased scientific skill and high technical expertise, modern medicine has tended to be less human and more mechanic, the worst sufferers being the poor and the underprivileged. If medicare, just as legal-aid, should have any meaning for those who need it most, it must prominently find a place in a public service agenda in which the best of professionals – surgeons, consultants, specialists – would be required to serve the most poor and the most deserving.

**Justice H Suresh**
Retired Judge, Bombay High Court,
Mumbai.

# Introduction

**Amar Jesani**

"How can this be? The doctors said she was getting better!" How often have we heard the lament. And how very often do most people attribute the tragedy the death of a loved one to ill-luck, destiny, etc. Yet, as the cases in this book tell us, there are many occasions when both medical science and medical practitioners betray the faith placed in them by people. Medical negligence and malpractice are not new phenomena, but in recent years in India, they are being recognised as offences in the eyes of the law.

This book is, partly, an outcome of the work done by members of the Bombay group of the Medico Friend Circle (MFC), their friends and supporters over the last 10 years. The MFC is a nation-wide organisation of doctors and health activists working for pro-people changes in health care for the last 24 years. The MFC evolved as a national level thought current of socially conscious doctors and health activists in the early 1970s to fulfill their need to meet, share experience, evolve alternatives and discuss health related issues of the country. Since then, its members have been meeting at least once a year to discuss health issue(s) and bring out the *MFC Bulletin*, 231 issues of which have already been published. These core activities of the MFC are self-financed by members. Its members did not have a regular local activity in the name of the MFC. However, in the aftermath of the Bhopal gas disaster and the substandard gycerol (drug) tragedy at the J J Hospital (and the Lentin Commission inquiry into it), these members, individually and together, were increasingly called upon to intervene and make their views known, particularly on the criminal neglect shown by the medical professionals. While their collective work became publicly known as that of the MFC, the formal constitution of Bombay group came in 1988 when on November 7, Dr Arun Bal, a consumer activist, was dismissed from a hospital allegedly for his campaign against the marketing of hazardous drugs by the pharmaceutical industry.

MFC members immediately took up the cause of the victimised doctor, published pamphlets for public education, helped orga-

nise a public meeting and a demonstration in defence of Bal. The formally constituted Bombay Group found a prominent place and soon requests for taking up various health related tasks poured in. While the group laboured well on many general issues, it did not at that point envisage regularly helping individual cases of medical malpractice till P C Singhi arrived in Bombay with a mission to obtain justice for the pain suffered by his wife due to the alleged negligence of a top cancer specialist.

In December 1989, on the advice of the national convenor of the MFC, Singhi met the Bombay group members and Bal. While we sympathised with him and his cause, we were somewhat sceptical about the possibility of getting justice from the medical council and the courts. We, however, had no hesitation in inviting him to present his case at the workshop on 'Medical Malpractice and Ethics' conducted by the MFC as a part of the national level conference on 'Social Movements, Human Rights and Law' organised on December 27-30, 1989, in Bombay. His presentation and overwhelmingly positive response from activist lawyers convinced us that the MFC should also be handling individual cases. It was clear during the discussion that for medical malpractice there was no separate statute, and the tort law on it had not adequately developed in India for the sheer lack of number of cases being fully tried in the court. We all realised that unless patients or their relatives were provided good moral and technical support to fight for justice in the courts, it would be difficult to change the situation. Soon after, on January 6, 1990, the MFC organised a press conference demanding that the medical council should take stern action against unethical and negligent medical practice. At this press conference, Singhi's presentation was widely reported by the media.

We were completely swayed by the overwhelming response we received from people who suffered at the hands of the medicare system. The very fact that an organisation of medicos was making a public commitment to help all those who had genuine grievances against the system helped many to come forward with their problems. We were literally flooded with cases.

In retrospect, what we witnessed was a veritable explosion of pent up anger of people against the system which has got substantially alienated from people's needs. The MFC perhaps acted as a catalyst and a channel for articulating people's grievances. The rising cost of medical care, the growing arrogance of providers and their refusal to be socially accountable and sensitive, had created objective ground reality to enable the MFC to play the role of catalyst. In this initial period, the way the MFC campaigned on the issue also helped in generating such a response. The MFC plunged straight on, strongly condemned medical negligence and medical insensitivity, refusing to accept the argument that it was the handiwork of few black sheep in the profession by questioning the indifference shown by the medical councils and medical associations. By refusing the counsel of others to tone down the campaign, MFC created a sense of urgency and forced all concerned people to respond. Consumer organisations started finding their rightful place in the debate and in handling cases.



In the first three years (1990-92), the Bombay group was approached by about 60 victims or their relatives. For an organisation having no office, no full or part-time employed staff and no financial support, it was a daunting task. The people who came needed more than technical support. These individuals had been somewhat traumatised by the system. They wanted to talk about their experiences again and again. They wanted somebody to empathise with them. All of them invariably wanted information so that they could understand what went wrong. One common complaint was doctors' indifference to their information needs. Most of them did not find the idea of becoming litigants and fighting long drawn cases, attractive. In fact, they were cynical about the efficiency of the judiciary in giving them justice and their opinion of lawyers was not better than the doctors against whom they were complaining.

Very few cases that came to the MFC actually went to court and medical councils. Those who have pursued their cases, have largely done so to achieve something 'good' to establish legal precedents which could deter doctors from repeating similar mistakes and could provide a means to future victims for getting justice. Most of them have, in their petition for compensation for the harm sufferred, made explicit commitment that if the compensation were granted by the court, the amount would be used

for charitable purposes. Most of these are individuals who have shown exemplary public spirit even at the time of losing their near and dear ones at the hand of negligent doctors. Three of the four case studies (that by P C Singhi, Raghunath Raheja and Yasmin Tavaria) presented in this volume belong to this category. Their desire to share experiences with people was so strong that they have written their own story of trials and tribulations. Undoubtedly, this is something remarkable, as one needs some courage to re-live the traumatic days of the tragedy and its often frustrating aftermath. The last case study, done by the public spirited journalist, Saroj Iyer, is of a woman who became comatose as a consequence of an allegedly negligent caesarian section delivery. She remained in coma for five long years and died only recently. This is one of the most tragic cases in which the patient's family were completely devastated, emotionally and financially.

Many of these victims had not contacted the MFC in the first instance. Most had begun their search for facts on the assumption that the particular doctor who treated their relative or friend was perhaps 'bad'. They continued to hold the profession in high esteem. However, they were in for many shocks. They found in time that the doctor and the hospitals could refuse to give them a copy of the medical records (the case papers). Since the MFC always needed a copy of the case paper in order to understand what exactly went wrong and to guide them accordingly, they had to use some ingenious ways to obtain such a copy. They were shattered to learn that other doctors, after going through the case records which they had obtained after great struggle could tell them that the negligence was the cause of death or injury but not give the same opinion in writing. In Raheja's case, a doctor even charged money for going through the case record and for giving the opinion in writing, but refused to sign it. Singhi encountered a situation where he found that the hospital had changed its operation theatre register to protect the doctor against whom he was fighting the case in the medical council. Tavaria, on the other hand, was amazed to learn that the regulatory authorities of the government and municipal corporations had no idea of what standards for the private hospital they were supposed to regulate. Ashwini Rane (nee Deepa



Parab) died in deep coma without getting a single hearing from the consumer court simply because her relatives and friends failed to persuade even one doctor to give in writing an opinion that her coma was the result of negligent medical care while the court continued to demand such an opinion as a precondition to admitting the five-year-old case.

These testimonies in this volume bring out numerous such issues. These people, who had high respect and hope for the medical and judicial system of the country, are now much wiser. What they have learnt, and that is clear from their narratives, is that the patients and people are pitted against a very powerful, well integrated, deeply entrenched and largely money or profit driven private medical care system. Of the cases narrated here, Singhi has travelled the longest in getting justice. For he got a favourable judgement or order from the medical council, though the doctor was only warned as a punishment. But in order to get the criminal case against him moved further, he had to travel all the way to the Supreme Court in order to get the preliminary part of the trial cleared so the local court could begin the trial. Tavaria became part of a public interest litigation to enforce minimum standards for private nursing homes and hospitals in Maharashtra state. As she mentions, it resulted in the high court appointing a committee to oversee the implementation of the Bombay Nursing Homes Registration Act. On the other hand, Raheja lost his case against the medical council in the high court, filed an appeal against it in the Supreme Court, where also he lost; but the judgement of the high court ratified his claim that patients have a right over the copy of medical record and the doctor and hospitals should provide a copy to them. Despite all the frustrations experienced by these people in their struggle, they have not allowed their efforts to slacken. This volume is a modest attempt to document their sufferings, their pain and their struggles and most importantly, their never-say-die heroism.

* * *

The book is in three sections. The first is in the nature of a preamble which attempts to locate the problem in the physical reality of today's medical care system. The second section, comprises the four case studies , the narratives of struggle. The

third section is a collection of articles which elaborate on the issues and problems which emerge in the case studies.

This section focuses on the ethical responsibility of the medical profession and examines the functioning of the medical councils. Ethics are inseparable from the medical practice and therefore, medical malpractice is only a public expression of the erosion of ethics and the profession's failure to internally self-regulate its members. It draws attention to medical negligence, ethics and consumer protection. In this part, a detailed analysis of the meaning of negligence and the legal remedies under the Tort Laws available to consumers is discussed. In another article, the extension of the Tort Law facility in the Consumer Protection Act and how the objections raised by the medical profession to the CPA are misplaced, is explained.

This book has not of course covered all aspects of medical malpractice, as for instance, those related to human rights issues, namely, the general right to minimum health care and doctors' role in human rights violation. However, during this period the MFC has done some work on the subject. Its members participated in teams investigating human rights violations such as police custody deaths, rape and police firings. The 1991 annual meet of the MFC also discussed at length the policy changes in order to make basic minimum health care universally accessible to people. In all these works and discussions, ethical issues and patients' rights were prominent.

Lastly, this book is a collective effort. Many individuals participated and played important roles in buiding the campaign against medical malpractices. Likewise for the production of this book, many individuals donated their hard earned money and many provided their expertise, skill and time. While at the a end a few individuals always take credit for editing a book like this, the contribution of all whose names do not appear on the cover has been as vital as that of the editors.

We hope that this volume makes a modest contribution by informing people about the present state of medical care in our country and what they can do to make it socially accountable.

# I
# Contours of Care

# Misuse of Medicine

**N H Antia**

There is no field of human endeavour where misuse of privileges, authority and funds can be entirely eliminated. Hence society devises methods for limiting such misuse in the form of rules, regulations and legal measures even though enlightened self monitoring and self restraints are ideal. What differentiates professions from trades is that the former not only possess special knowledge and skills but also evolve a code of conduct and ethics to monitor their own members. This is in order to ensure not only the level of technical competence but also the obligation to the society which has entrusted them with responsibility and has placed trust in them. The medical profession has enjoyed a uniquely privileged position because of its technical skill as well as the intensely personal relationship which develops between a doctor and his patient, whereby the latter puts his/her entire faith in the doctor who not only cures but also cares and consoles the patient as well as the family. The epithet 'noble' is symbolic of the love and respect that this profession has enjoyed over the ages, which is somewhat akin to that of the priest.

It is unfortunate that there is now a rapid deterioration of this happy relationship between the profession and society at large. A degree of suspicion and mistrust pervades this relationship today. Before we blame the profession as a whole, let us not forget that there still exists the same relationship between the family physician and his clientele; only that this breed is rapidly diminishing as a result of the new, impersonal and materialistic trends which affect not only this profession but also the rest of society of which they are an integral part.

The wholesale adoption of the western model by our policy and decision makers after independence, based on an alien culture and its science and technology has shaken the entire social and economic fabric of our society and distorted age-old values associated with our civilisation and its culture. It has

polarised our society with a small, wealthy elite group marginalising the vast majority whose life is being increasingly degraded, as clearly observed by the burgeoning urban slums. While this western science and technology has given the knowledge and technology to provide for the basic needs of everyone on this planet, yet, because of its very materialistic nature and lack of a human and moral basis, it is used chiefly as a tool for aggrandisement and exploitation. Such misuse is not only restricted to the western nations where it has originated, but is also rampant in the poor countries, in the hands of those who have been able to obtain access to this technology. The gross misuse of such knowledge and technology in the field of medicine is demonstrated by the fact that the most simple, cheap and efficient aspects of the cure and control of communicable diseases (which still remain the major health problem for the vast majority of our people, especially the poor) are neglected and undue emphasis is paid to the most expensive, complex and cost ineffective diseases like cancer, heartstroke which affect the small, affluent sections of our society. This clearly demonstrates that the dominant consideration in the import and use of such science and technology is dictated by the requirements of the rich and that of the medical profession rather than the needs of the vast majority. In the process, medicine is being converted from a profession to a lucrative trade in human suffering; an area where consumer resistance is at its lowest.

The gross overproduction of doctors, drugs and sophisticated medical instruments and that too, of the wrong type has ensured that malpractice has been built into our present health system. Unfortunately, over the years, this has become an accepted form of medical practice by both the medical profession as well as the public. This is further compounded by the absence of any regulatory measures like public information and education on health and suing for malpractice, as exists in the US and many other western nations.

In the case of the urban rich this is demonstrated by the unnecessary, excessive and even dangerous investigations and medications, inclusive of surgery and the pressures to impose the latest and most expensive glamour technology imported



from the west regardless of its appropriateness. Also, the patient or the public is seldom informed of the attendant dangers which are reported in western journals, leave aside the far greater shortcomings in our own limited experience. Due to availability of easy money, the rich are unwittingly at the greatest peril of iatrogenic (doctor-made) diseases, as is demonstrated by the mushrooming 'five star' urban hospitals with the latest specialities, the latest scanners and the latest drugs and operations. Intensive care units are indiscriminately used, even for terminal care patients, who now have to end their life in stark aseptic conditions monitored by the latest gadgets, rather than in an ordinary hospital bed or preferably in the home, surrounded in their last moments by loving and caring relatives and friends. Each one of these facilities have their specific limited use, but when unintelligently or deliberately pushed to their limits by those trained as technical robots or for satisfying their monetary greed, these 'wonders' of modern science prove to be counter productive, if not actually harmful.

The growing middle class has now been caught in a cleft stick between providing the latest medical care like renal dialysis, kidney transplant and coronary bypass surgery for their loved ones and being pauperised in the bargain. Many search for a good, old fashioned family doctor, who is now in short supply, or turn to other cheaper and more acceptable alternative systems such as ayurveda and homeopathy. Without insurance and adequate financial resources, the thought of illness has become a source of anxiety and neurosis for this rapidly enlarging section of our society.

For the vast majority of the poor who live in villages and urban slums, this poses an entirely different problem. While the middle class is their role model, they can hardly conceive of using the private hospital with its specialists or even the nursing home for their medical needs. And yet they too have been hooked by the medical profession, albeit by those in the lowest rungs, to the universal injection as a panacea for all ills. The 'blunderbuss' therapy of Rs 20 or more for a so-called 'cocktail' injection consisting of an antibiotic, corticosteroid, vitamin B, antihistaminic and analgesic is now familiar even to most

villages leave aside the older 'heat' producing injection of calcium gluconate. The public hospital, whose malfunctioning was so starkly revealed by Justice Lentin, remains their last resort. Fear of these institutions now drives them to small, unhygienic private nursing homes, often after a preliminary visit to the moneylender. The government primary health centre, which was designed to serve the preventive, promotive and basic curative health needs of the 70 per cent of our population that lives in rural India, has ceased to undertake any of these functions as a result of its almost total devotion to family planning and its accessories like immunisation and MCH. Shrouded in secrecy, the PHC is unaccountable to the people for whom it is meant.

What is it that has led to this lack of accountability of the public sector and the exploitative nature of the private one? The answer lies clearly in the inappropriate western model that has been chosen for the development of this country. While we may forgive Nehru for being enchanted with the postwar euphoria for western science, the continuation of the use of this model, that too in its worst aspects, despite ample experience to the contrary, can only be ascribed to the selfish and exploitative nature of those who continue to promote and operate this form of development.

It is regrettable that this type of medical practice now poses a threat to the health of our people. The public health colleges produce doctors who are mostly trained for and work in the private sector. It is inconceivable that any sane politician honestly believes that private medical colleges, which levy a capitation fee of several lakhs in declared and undeclared monies, are for the benefit of the rural masses. The mad rush for securing the highest marks for admission to government medical colleges, or paying high capitation fees by the rich, for their children who cannot get into the former colleges, does not demonstrate love for the health of the people, but a clear indication of the extent of safe monetary returns that this profession ensures them. The type of medical education and even worse, the values inculcated in them are directly opposed to the health needs of our people. Permission to produce 60,000 drugs and formulations (costing Rs 3,600 crore), when the



WHO lists only 258, is surely not for the benefit of the people but that of the pharmaceutical industry and those who give them licences on the basis of kickbacks. The multinationals who control the major drug companies and increasingly, the medical instrumentation industry, do not come to India for the health of our people.

The medical profession and the associated health industry have the unique opportunity to trade in an area where consumer resistance is at its lowest, as a result of fear and ignorance. Public ignorance and absence of consumer resistance is demonstrated by the fact that malpractice insurance premium of doctors in India is Rs 100 per annum, while that in the UK it is over 1200 Pounds Sterling, and for certain specialities in the US over $ 60,000 per annum. This is not to advocate legal action as the optimal way for improving the health services, but under the prevailing conditions of increasing material values and human greed, public awareness and threat of legal action remain the only way out.

# Medical Practice: Private and Public

Amar Jesani

What role does medicine play in improving the health status of the people? This question is of fundamental importance, but its answer is more or less practically settled by the research done in the last one and half centuries. As early as in the mid 19th century, Rudolf Virchow who did pioneering work in the study of infectious diseases and epidemiology, stressed the importance of social, economic and political factors. He indeed coined the slogan that "Medicine is a social science and politics nothing but medicine on a grand scale". These views of Virchow have been reinforced by many researchers since then. A decade and half back, Thomas Mckeown undertook a historical analysis of data on the developments in the socio economic fields, their effect on the health of the people and the contribution made by medicine. He concluded that though clinical medicine had its own place in health care, other factors like nutrition, environment, behaviour, etc had long term impact on the health status. It is now widely accepted and also reinforced in the Alma Ata Declaration of the World Health Organisation, that health should be viewed as a part of development, and the political will of the government plays a decisive role in orienting development for improving the health of the people.

Since the health care services also contribute, albeit in a limited way, to the improvement of health status, it is relevant to ask: what should be the nature of medical practice so that it can make maximum contribution in the nation's efforts to achieve better health status for the people? In other words even if we accept that social, economic and political issues are beyond the scope of medical personnel, what should be the nature of medical practice in order to make it more effective? This question is of great relevance, especially for underdeveloped countries which cannot afford high cost medicine.

The Bhore Committee Report (1946) while emphasising the need for rapid socio-economic development for the success of



its health care plan, did not want medical practice to remain confined to its traditional role of curative care. In fact it wanted to orient medical practice to actively aid in the improvement of health status. Thus, it suggested that "preventive and curative work should be dovetailed in order to produce the maximum results". This was argued not from an idealist and a moralist, but from a very practical standpoint, for "a combination of curative and preventive health work is in the best interest of the community and of the professional efficiency of the medical staff employed. In fact the two functions cannot be separated without detriment to the health of the community".

Health care in the private sector has been almost entirely curative in nature. Of late, efforts of the government at creating consciousness about immunisation and its actual provision through a wrongly conceived but high powered target oriented programme have created substantial markets or demand for immunisation in the private sector, too. Many private practitioners nowadays provide immunisation services. But the comprehensive or integrated medical approach is otherwise effectively ignored by the private sector. The overwhelming majority of doctors (estimated to be over 85 per cent of all systems of medicine) working in the private sector, practise chiefly curative medicine. Not only that, since the expansion of the private sector is taking place rapidly and accounts for over 80 per cent of the health expenditure of the country, the overall trend is towards curative medical care. This is detrimental to the interests of the community and is progressively reducing the social efficiency of the medical profession in making contributions towards improving the health status of the people. Thus, it is clear that the greater the importance given to the private sector (which is not controlled in the health planning process), the more reinforcement will be provided to the almost exclusively curative medical practice.

In the public sector, on the other hand, the situation is a mixed one. The urban component of the public sector in many ways resembles the medical practice in the private sector. And indeed a greater part of the public sector resources is spent on urban health care. This is also true for the rural hospitals or the community health

centres (CHCs). However, when we take the primary health centre (PHC) infrastructure separately, a different picture emerges. All the health workers at the PHC and the sub-centres are supposed to practise comprehensive medical care. This does not apply only to the doctor who is the leader of the health team at the PHC, but also to the paramedical staff. The paramedical staff, the health workers and the health assistants are supposed to provide curative, preventive and promotive health care. The paramedics are no longer trained only to help the doctors but to provide all aspects of health care in a relatively autonomous manner. They are also required to run sub-centres, with drugs made available for curative care; and the doctor normally supervises from a distance as the doctor is located at the PHC. As a team leader the doctor is formally accountable for the performance of the PHC as a whole. Thus, at least, he comes under administrative pressure to pay some attention to the preventive and promotive work. The now largely defunct village health guides, were also trained in order to provide comprehensive primary health care.

Unlike the private sector and the urban public sector, medical practice in the rural PHCs is sought to be oriented towards comprehensive care. This does not mean that this orientation has been successfully implemented in actual practice. Almost all government reports, committee reports and numerous studies have shown inadequacies in implementation. But at the same time, though done in an unacceptable bureaucratic way, doctors at the PHCs have been forced to pay attention to the promotive and preventive medical care in spite of them not being so prevention-minded and being more interested in doing their illegal curative private practice. The preponderance of curative medical practice in the health care services in our country is chiefly due, directly or indirectly, to the domination of the private sector. This is compounded by the government's almost non-implementation of the preventive care orientation in the urban and its weak implementation in the rural public health care sector. All these contribute collectively to the low overall social and professional efficiency of the health care services in our country. And indeed this situation, as the Bhore Committee had put it, is detrimental to the interest of the community.



## Private Sector

Although a lot has been written about the predominant curative care orientation of health care services in India, very little is written about how curative care is actually practised. Traditional organisation of curative medical practice revolves around the preponderance of general practitioners (GPs) and family physicians (FPs) supported by the consultants. The first two categories could be combined in a single practitioner in the sense that the family physician is normally a general practitioner but all general practitioners are not family physicians. In the traditional organisation of medical practice, the consultant plays a role of specialist to whom the GP/FP refers cases for getting advise on diagnosis and the line of treatment to be pursued in cases requiring greater skill or facilities. This organisation of medical practice is so ingrained that the code of medical ethics has laid down certain general rules regards the relationship between the GP and the consultant.

But this traditional relationship between the GP and the consultant is undergoing a profound change. C N Chandrachud (1970) in his *Memories of an Indian Doctor* observed

> "(now) it is common for a consultant to see and examine a patient without being called in by a general practitioner. A consultant often deals directly with the patient and carries out further the job of giving injections, etc. I have known consultants who have maintained dispensaries much against the rules and dispense medicines in the dispensary. Some of the consultants have almost made it a rule to ask a patient to seek consultation after a week or fortnight and tempt the patient with the offer that the fees for the next consultation would be half of what was charged for the first consultation".

What Chandrachud observed in the 1950s and 1960s as growing unethical behaviour of the consultant has now become established practice. The intense market competition and the profit orientation in the virtual absence of adequate machinery to implement professional self regulation, does not honour old traditions nor the traditional code of ethics.

Another change that has come about is in the location of a doctor's medical practice in the economic system. Earlier, the

doctor was a person owning his/her skills and instruments, compounding drugs in his/her clinic and treating patients. He could be well described, in the terminology of economics as an artisan or a petty commodity producer, who produced use value and sold them for exchange value. However, in modern times, the relationship between the customer (patient), the trade person (doctor) and the technology used for curing (drugs, instruments) is no longer of the old type since the doctor as a professional is essential for the sale and the use of goods produced by the health care industry, s/he while acting as 'a small commodity producer or an artisan', simultaneously works as an 'agent' (or a sales person) of the industry (drugs, equipments, and now even hospitals) in the market for the realisation of profit. This new role of the doctor is almost universal because he or she no longer gathers herbs and chemicals, and compounds drugs. The increasing technological use (including hospitals as technology) in diagnosis and the treatment has, therefore, thoroughly changed the social organisation of medical practice.

Convergence of interests of the industry and the practising doctors takes place most visibly in the 'for profit' medical care. In our country the private sector almost exclusively works on user charges, because insurance coverage is negligible. Even where the state partially provides insurance, as is the case with industrial workers, the situation is not so rosy. In any case, insurance schemes for industrial workers and the government employees have not helped in making any significant dent in the practice of user charges in the urban areas. Insurance schemes like Mediclaim by the United India Insurance have actually helped in the increasing usage of hi tech, high cost medical care in the private sector.

In our country there are no restrictions or no guidelines from the Medical Council or the state on the quantum of fees charged by the doctor, the nursing home or the hospital. In the 'for profit' private sector this situation has encouraged cost escalation. Doctors earn disproportionately high income as compared to their declared income. If the reports appearing in the print media are any indication of the trend, then the complaints of the under-the-table charges by doctors and hospitals are on the increase.



In contrast to this observed trend, no reliable information on the earnings of doctors is available. The income tax authorities have not published any survey of the medical profession's income at any time. In a study of 152 doctors (119 of them working in institutions) located in Jodhpur (Rajasthan) by Ambika Chandani, it was found that the average income of private medical practitioners from their practice was Rs 783.80 per month. This is undoubtedly a ridiculously low figure for the income of city-based doctors. Some pilot studies have been conducted on doctors' income. Alex George in a survey of 33 doctors (general practitioners, specialists and allopaths, non allopaths) in Bombay found that their average monthly net income was Rs 18,333. But in a relatively larger survey of 177 doctors in Delhi done by Kansal at the Indian Statistical Institute (ISI), it was found that the average net income of a doctor practising at clinic or residence was Rs 29,800 per month and of a doctor running a nursing home it was Rs 80,000 per month! These findings indeed confirm our earlier diagnosis of profiteering in the 'for profit' medical care, if not for the entire country, at least for doctors in our metropolitan centres.

While millions of people in the rural areas have no access to basic health care, in the urban areas where curative care medical practice is highly concentrated, the rising cost of medical care is becoming an important issue. This rise in cost is not related only to the earnings of doctors, but also to the use of high technology. There is a phenomenal increase in the production and import of hi tech medical instruments. In addition to increasing cost, it encourages unethical 'cut practices' and direct advertisement of such technology to the general public. This becomes necessary because the high investment involved in the purchase, housing and maintaining of such instruments and for getting adequate returns on such investment, their continuous and even unnecessary use becomes an economic necessity.

The issue of over medicalisation and iatrogenesis were forcefully raised by Ivan Illich and Ian Kennedy. In the last one decade, the efforts of the constituent organisations of the All India Drug Action Network and many other such socially oriented health, science, women and consumer organisations

have helped focus attention on the production and sale of irrational medical goods and their use by doctors. Modak (1984), Phadke (undated), Jayarao (1985) and many others have conducted scientific scrutiny of drugs produced by the industry and used by doctors. The ICSSR/ICMR Committee (1981), too, expressed serious concern about the pattern of drug production in our country. All these efforts by socially conscious organisations and individuals have demonstrated that a large majority of 50,000 drugs and formulations available and used by doctors in our country are hazardous, useless, unnecessary and irrational. Such products not only harm the interests of consumers and inculcate irrational medical practice, but are also causing a waste of resources and increasing the cost of medical care.

Another example of irrational practice is the indiscriminate use of injections. In a study of 100 doctors in Bombay city by Uplekar and Rokle (1987) it was found that the injections most commonly used by the general practitioners were antibiotics (46 per cent) and vitamin preparations (24 per cent). In their study the most frequent use of injections for vaccination was mentioned by only 4 per cent of general practitioners. Further, when they interviewed 10 drug distributors supplying drugs to the general practitioners practising in the areas surveyed, they were told that 'dexamethasone injection' (a life saving very useful steroid, indiscriminately misused) was one of three top selling products. A growing trend in medical practice is of irrational therapeutics, over prescription, unnecessary investigations and unnecessary surgeries.

Why are doctors resorting to such practice? There are many reasons. The first factor responsible for this state of affairs is 'ignorance'. To say that doctors are ignorant of rational medicine may sound a contradiction in terms, but unfortunately it seems so. In two studies of prescription practices by private general practitioners in Bombay city, Uplekar (1989a, 1989b) found that they had grossly inadequate knowledge of highly prevalent diseases like leprosy and tuberculosis as well as of the standard regimen for their treatment.

Second, in our country there is no systematic and effective continuing education of doctors engaged in medical practice by



independent scientific body. Once registered with the medical council, the doctor is not required to undergo retraining or examination for renewal of registration. For non allopathic doctors, continuing education is virtually non-existent. As a result, there is no effective mechanism to provide correct information to doctors and to orient them to rational medical practice. This lacunae in doctors' continuing education is sought to be filled up by the industry through their medical representatives (MRs). Unethical practices like providing drugs free to the doctor in the name of samples, cut practices, commissions, treating doctors in posh hotels by organising the industry-sponsored seminars, offering foreign trips and so on by the industry have been reported. All these things make doctors ignore cost and rationality of drugs used by them.

Of these factors, the most important one is private practice in the unregulated market. What happens when health care is provided on the market? We know that health being a state of well being of the body as well as the mind, it is not tradeable. In the achievement of health, health care plays an important role but not a central role. Health care, however, is tradeable. In a market situation, thus, health care becomes a commodity. For an exchange to take place on the market, the demand for health care from the consumer is essential. The demand, for obvious reasons, is chiefly of curative care. From this it follows that in a society where private practice in unrestrained the market dominates, health care provision is also dominated by the curative orientation. Now, the doctors themselves play a crucial role in generating demand for health care by the consumer. This is for the simple reason that health care is a different kind of commodity, the patient being always much less informed than the supplier, the doctor. Further, the information with the patient is usually unscientific and irrational. Above all, an ill person is vulnerable and usually has no alternative but to choose from the alternatives suggested by doctors. Thus, the dual role of doctor's, in generating demand as well as in being a monopoly supplier, creates a situation of supplier induced demand.

That is why many studies [Auster, and Oaxaca 1981; Green 1978; Funchs 1978] have shown that when there is an increased

supply of health care providers instead of lowering demand, as it should happen in the classical market, there has been normally an increase. This is usually brought about by increased number of unnecessary investigations and surgeries, irrational drug prescriptions and so on. In a way, thus, the market competition in health care is dominated by irrational, unnecessary and undoubtedly harmful medical practices.

Public sector health care does not merely co-exist with the private sector. Since the private sector is dominant with almost 80 per cent of doctors working in it, the public sector is in many ways led by the private sector. This does not need much explanation as it is quite obvious. It is evident in the location of medical colleges, in the content of medical education, in the way Medical Council function and so on. The norms of curative medical practice are, therefore, set by the private sector. The value system of private sector medical care, namely commercialisation, high technology orientation, etc have come to dominate the practice of medicine. The public sector is also greatly influenced by this value system of the private sector in curative care. As a result, one witnesses increasing illegal or unofficial private medical practice by government doctors in PHCs and hospitals. There are even agitations by doctors to make their private practice official. It is not unusual either to see government doctors doing private practice, sometimes even using the medicines from the PHC and the hospital.

Although the state is involved in the production of drugs, the PHCs and hospitals are supplied drugs in inadequate quantity and in an irregular manner. Often a significant proportion of drugs supplied is irrational, useless and hazardous. Due to the inadequate supply and corruption, even at the government hospitals patients are given prescriptions to buy drugs from the open market. From our experience we have strong reasons to believe that a majority of drugs prescribed by government doctors for purchase by patients are combination drugs and are irrational. Further, the average cost of medicine borne thus by the patient is perhaps three to four times the average expenditure made by the government on drugs for a patient. That is why we find that the drug industry's medical representatives visit the



government doctors in the same way and for the same purpose as they do doctors in the private sector.

Just before independence, the Bhore Committee expected the public sector to lead in health care development. However, in reality, it is being led by the private sector. An analysis of corruption, so-called inefficiency, political problems, problems of orientation, etc, of the public sector gives only a one-sided picture which reinforces the pro market privatisation votaries. It is also misleading to assert that malfunctioning of the public sector provides a scope for the expansion of the private sector. A holistic approach first recognises the predominant position of the private sector (which it could acquire undoubtedly due to the conscious policies of the government) and its negative influence over the public sector. That is the reason why there is little to choose between *curative* medical practice in the private and public sectors.

## References

ICSSR Committee (1981): *Health for All: An Alternative Strategy*, Indian Institute of Education, Pune.

Jaya Rao, Kamala (1985): 'Tonics: How much an Economic Waste' in Ashvin Patel (ed) *In Search of Diagnosis*, Medico Friend Circle, New Delhi.

Modak, Shishir (1984): 'Anti-Diarrhoeal Formulations: A Rationality Study', Rational Drug Policy Cell, Pune.

Phadke, A R (undated) 'Scientific Scrutiny of Some Over-the-Counter Drugs', Unpublished paper for Medico Friend Circle.

Uplekar, Mukund (1989): 'Prescribing Behaviour of Private GPs of Bombay in Treatment of Pulmonary Tuberculosis.

Auster, Richard and Ronald Oaxaca (1981): 'Identification of Supplier Induced Demand in the Health Care Sector' *The Journal of Human Resources*, Vol XVI, No 3, Summer, 327-342.

Green, Jerry (1978): 'Physician Induced Demand for Medical Care' *The Journal of Human Resources*, (Supp): 21-34.

Funchs, Victor (1978): 'The Supply of Surgeons and Demand for Operations' *The Journal of Human Resources*, (Supp): 35-56.

# II
# 'Our Struggles'

# *Why Do I Decry Prafulla Desai?*

**P C Singhi**

All those who are born have to die one day and no one can have a grouse against this universal law. The question arises, why then do I anguish over the death of my wife Leela on February 26, 1989 while under the treatment of Prafulla Desai, cancer specialist and former director of the Tata Memorial Hospital?

Leela was diagnosed as having breast cancer in July 1977 at Bombay Hospital by Dr J C Paymaster who operated upon her and removed her left breast. Unfortunately, soon after, Leela started bleeding heavily,leading to a drastic fall in her haemoglobin level. She had to be given blood transfusion. We were living in Jaipur then and Paymaster had advised her to come to Bombay every three months for a check-up. After sometime, Leela became almost normal except for the psychological feeling of not having a breast. It was unfortunate but so what? God had destined so and she accepted it boldly. Leela was a teacher not by profession but by commitment. She taught girls for about 20 years in schools, 10 years she taught only the deaf-mute. She almost adopted a girl for whom she found a suitable match and got her married. She continued teaching even after surgery. We thought now she would have no problem and life would move on as usual. Alas, it was not to be.

I was an officer of the IAS cadre in Rajasthan and had to move from place to place. In 1984, I was posted as collector and district magistrate in the tribal district of Banswada on the Gujarat border. Leela was with me. One morning, I found that I was passing blood in urine. I called the local doctor who could only advise me to go to either Ahmedabad or Jaipur and consult a specialist. Leela was shocked. She refused to go to Bombay for her three-monthly check-up, leaving me in the hospital at Jaipur. Dr K C Gangwal, a friend and an eminent urologist in the SMS hospital at Jaipur broke the dreaded news that I too was suffering from cancer. The carcinoma was in my bladder. I was operated upon and Leela took care of me for a full month in

Jaipur. Her check-up got delayed by a month and I could take her to Bombay only in August.

In the meanwhile, she had developed a breathing problem. The chest x-ray and the blood test reports clearly indicated that Leela now had lung cancer. Leela was instantly hospitalised. Paymaster started chemotherapy as her condition was serious. He told us that she may not survive long. My daughters, Vanmala and Ruchira, and I were in tears, heart broken. Leela told me that she wanted Ruchira to get married immediately. I also agreed. Ruchira decided to postpone her final examination of B Arch and get married to make her mother happy. Fortunately, we had no problem finding a suitable boy. Ruchira had done that herself and we welcomed her choice. Rameshwar was explained the situation on telephone at Ahmedabad and he agreed. His parents were sympathetic and understanding. The marriage was performed in Jaipur to Leela's joy.

Luckily, Leela's condition, too, had stabilised to some extent. I decided to take Leela to the US for treatment. The only hurdle was money. I decided to sell off my only house in Jaipur to the first buyer within 24 hours. Leela and I went to New York with a letter from Paymaster addressed to Dr Urban, a cancer specialist in Sloan Kettering Memorial Hospital. He examined Leela and referred her to Dr Greenberg, a well-known chemotherapist of the same hospital. They appreciated the treatment given by Paymaster and offered some advise. We spent a month in the US, saw Washington, Niagara Falls and Disneyland and returned home to Jaipur. Leela passed another two years happily.

It was in October 1987 that the trouble started again. Leela had constant colic pain. Dr P K Wanchoo, cancer surgeon and Dr Kunal Kothari, physician, attended on her. It was found that she had some ascetic fluids in her lower abdomen. She was also examined soon after by doctors in Bombay Hospital who said she had a fibroid growth in the pelvic region. Anyway, I decided to take her once again to New York in the last week of October 1987. Greenberg who had treated her in 1985 also examined her but found nothing significant. Leela and I both felt relieved and



decided to stay in the US with Ruchira and Rameshwar who were there for four years. Leela wanted that both of us should get our eyes checked and change our glasses which had become shabby. One fine morning, we reached the chamber of an eye specialist for our checkup. While we were waiting for our turn, Leela went to the toilet and after a few minutes I heard her calling me loudly. I rushed and was horrified at what I saw. There she was in a pool of blood and was almost unconscious. I brought her out of the toilet and helped her to lie down on the couch. Nurses and doctor came running. They too, were stunned as they could not understand what the matter was. Leela could only say she was passing urine when blood flowed out and she could not control it. The ophthalmologist contacted Greenberg who advised immediate hospitalisation.

I called Leela's sister from Fresh Meadows, about 30-40 km away from New York. She reached us in half an hour. Leela was taken to the nearest hospital named Doctor's Hospital close to Sloan Kettering Memorial Hospital. It was about 9 pm Leela was admitted in the emergency ward. I did not have enough money to deposit at the hospital. But I discovered that unlike India, in the US no hospital can refuse admission to a patient in emergency and once admitted, the patient is given the necessary treatment irrespective of the payment made.

Perhaps, it was the most unlucky day for both of us because after that day, Leela was never normal and happy. The smile on her face disappeared. Dr Brockunier, the renowned gynaecologist examined her and suggested a hysterectomy. I was stunned. In that alien land and without any medical insurance or money ! Worse, we did not know what was in store. Friends and relatives, including one or two doctors, advised me to take Leela back to India for the operation. I asked Brockunier for the approximate cost of the operation. He gave an estimate of $20,000. To add to this was $5,000 more for my stay. I didn't know how I would manage Rs 5 lakh! My elation at getting Leela admitted to hospital without being forced to deposit money had evaporated. However, I had gone all the way to the US and so I asked myself, would it be a right to take her back to India for the operation only for the sake of money?

I decided to have Leela operated in the US itself by Brockunier. Leela was admitted to Doctor's Hospital in New York. She was taken to the operation theatre for examination. However, Brockunier found that it was just not possible to do a curettage because of an extraordinarily hard cervix. The doctor could only do a biopsy of the cervix. It was sent to the pathological laboratory of Sloan Kettering Memorial Hospital as well as Doctor's Hospital. The doctor said that if the biopsy reports were all right he would do the hysterectomy. The day for the operation was fixed. Leela was to be taken to the theatre at 4 pm. By that time, the biopsy reports were to arrive. At 4.10 pm Brockunier came to our room and told us the cancer traversed from the left breast to the entire pelvic region. It was impossible to operate. We realised the gravity of the situation. If the entire body had been affected by cancer, what hope was there now. I contacted Greenberg. He, too, was sad for Leela. He told me, he was sorry. There was no chance of doing anything except medicinal treatment.

We decided to leave Doctor's Hospital the following day. But the biggest problem was paying the bill of $ 5,689. I did not have that much money and did not want to borrow either, in view of the fact that friends and relatives had earlier advised me not have Leela's operation in the US. I decided to pay whatever I could and gave a letter to the hospital that I would remit the rest from India. Since I had been sponsored by the Rajasthan government, I mentioned this fact in my letter and forwarded a copy of it to the Indian embassy also. It came as a pleasant surprise that the lady-in-charge of Doctor's Hospital not only did not press for payment before discharge but actually said, we need not make even part payment if it was not possible. This was really a great relief. I think this outstanding amount of Doctor's Hospital was paid, if at all, by the government of Rajasthan after about three years.

We arrived in Bombay on November 28, 1987. Ruchira, our daughter also came with us. Immediately, I contacted Dr A K Mukherjee who was Paymaster's assistant in Bombay Hospital. He came to see Leela and went through the reports. He also informed us that Paymaster had retired from the Bombay



Hospital. I met Paymaster at his residence. He saw the US reports and agreed to start the treatment recommended. As per the report, one CEA test was to be done. Mukherjee said the test was not done in Bombay Hospital, so we went to Breach Candy Hospital. After having obtained the report, Leela was asked to start the first course of medicines prescribed by Greenberg and purchased from the US. Soon after starting the treatment, Leela again began bleeding vaginally. Mukherjee advised immediate hospitalisation. Since Paymaster had retired, I wanted Leela to be treated only by Dr P B Desai whom I had never met, but had heard a lot about. He was reputed to be the top cancer surgeon in India and internationally known. Luckily, Desai was the head of the oncology department in Bombay Hospital and Mukherjee was an assistant honorary under him.

Mukherjee gave me a note recommending Leela's hospitalisation which I took to the hospital manager, G P Sharma, who knew me for almost two decades. On December 9, was Leela admited under the care of P B Desai. She was admitted the same day. Two plates, one bearing the name of Desai and the other of the patient, Leela Singhi were hung on the door of room no 1005 (MRC). Mukherjee came the following day to see Leela and said that he would get one or two routine tests done before calling Desai. Meanwhile, I tried to contact Desai on the phone at Tata Memorial Hospital but could not get him. However, he came on December 17 to see Leela, accompanied by Dr Maniyar, the registrar of the oncology unit, and examined Leela, for about five minutes after which he decided that he would perform an operation to take out the uterus. Leela asked how he could do it when the US doctors had categorically ruled out any operation without serious complications. Desai replied, "We will take out the uterus. Don't worry... Don't worry". Leela reluctantly agreed, saying only that he should operate on her and none other. When Desai came out of the room along with Maniyar I followed him to the lift. "Please reconsider your decision", I urged him. Desai's face showed some displeasure. He said, "Mr Singhi, I know my job". I instantly apologised. I also told him that he himself should perform the operation. After a couple of days Mukherjee said he had spoken twice to Desai and that December 22 had been fixed for the operation.

I informed all my close relatives, including Leela's sister, Asha, in New York. Asha spoke to Greenberg about Desai's decision to perform hysterectomy. Greenberg was very upset and stated that surgical intervention would be a great folly as it would be very hazardous. But I was helpless. Perhaps, it was our destiny. All the relatives who gathered the day before the operation, questioned the logic of my consenting to get Leela operated. Both my daughters were also against it but did not resist too much.

### December 22, 1987: Doomsday

On December 22, Leela was wheeled into the Operation Theatre (OT) at about 8.30 am Desai came around 9 am. I tried again to urge him very politely to reconsider the decision, but he did not respond and walked into the theatre. We all waited outside nervously. After some time I heard Mukherjee call me from the halfopen door of the OT. I rushed to him Mukherjee's face was grim, his voice low and he appeared to be nervous. He said apologetically, "We could not do anything. We just closed the abdomen. Desai was in the next operation theatre but did not do anything. His response was 'very poor'. We are sending Leela to the room". I was stunned. We were in tears.

Leela was brought into the room. She was fully conscious because she had not been given general anaesthesia. She narrated the entire sequence of events that took place in the OT which left us even more devastated. "Mukherjee opened my abdomen with the help of Maniyar and Rashmi Kotak, was the anaesthetist. On seeing the condition inside, Mukherjee got nervous and sent Maniyar to call Desai from the OT No 1. It took some time. Mukherjee asked the ward boy to keep the door of OT No 2 open so that he would see when. Desai came out after some time and Mukherjee rushed to him. They talked just outside the door of OT No 2. Mukherjee explained to him what he saw inside the abdomen and asked him to come and see me on the operation table. But I heard Desai telling Mukherjee, 'Well, Mukherjee, in this situation, nothing can be done. You close the abdomen.' So saying this internationally known cancer specialist walked out". Leela was sobbing bitterly while



narrating this to us. Perhaps, she knew her end had come faster than expected. I sat beside her shocked to learn that Desai had not only failed to operate himself, but had also not bothered to come and see the opened abdomen in spite of Mukherjee's requests. I wondered why and where his opinion given in favour of operation only five days ago had gone wrong. He had refused to change his line of treatment in spite of protests from the patient, Leela, and the firm opinion against any surgical intervention by US cancer specialists. Leela and I had reluctantly agreed to the operation only on his assurance that he would perform it. Apart from that assurance, was it not his moral duty to see Leela on the operation table?

I was expecting Desai to come and see Leela at least after the operation. Two days passed. Mukherjee told us that Desai would come but another two days passed without any sign of Desai. I got upset. Meanwhile, C G Joshi, executive director of Bombay Hospital and G P Sharma, manager of Bombay Hospital, came to see Leela. Both of knew me. Leela had by this time, developed a fistula on her gastrointestinal tract. So fluids – including acid – were oozing out causing an intolerable burning pain. The abdominal dressings were increasing in number. I told Sharma to send Desai to see Leela at least once. He and Joshi both promised to do so but I waited in vain. On December 27, 1987, Sharma conveyed to me that he had asked Desai to see Leela but the latter had told him that he would not do so because she was not his patient. I almost collapsed on hearing this. How could he say such a thing?

Leela had been admitted under Desai. All papers in her medical file, all test reports and consent forms, day and night reports maintained by daily private nurses etc, had Desai's name and none else. Mukherjee was only an honorary assistant surgeon under Desai and was not authorised at all to admit any patient in his name or operate upon any patient independently. He was only to assist Desai in an operation and thereby to get one-third the fee which Desai charged.

I became suspicious. I spoke to Mukherjee. He too was upset. He was to go on leave for a few days for some personal work.

Leela had started complaining of severe burning around the fistula. I asked Mukherjee to call Desai to see Leela. He told me later that since Desai may not come, he would ask Dr Hegde to look after Leela in his absence. Hegde, an honorary cancer surgeon under Desai, came only once to see Leela in the absence of Mukherjee and that too very casually.

By now Leela was crying day and night because of the pain and burning due to bile and acids flowing out of the fistula. The number of dressings had gone up to 15 to 20 a day. She had practically stopped eating. The junior doctors, Dr Anil Sanganeria, I H Maniyar and Jain, were coming to see her as per their convenience at no fixed hours. Even when anyone of them was needed the sister-in-charge would send a message through a ward boy who would return half an hour later only to say that the doctor on night duty was not traceable. I had to run from one floor to another in search of them. The three special private nurses engaged by me from December 22, 1987 onwards through the hospital were the only ones to attend Leela all the 24 hours, each for eight hours. Leela's suffering had increased so much that even these nurses would cry. One of the nurses, M A Bashi, a 70 year-old-Muslim was so sad about Leela that she would sometimes herself cry. One of the nurses told me one day that Leela wanted to jump out of the window just to end her torture. We had to keep the windows closed. My daughters could hardly bear to see their mother's suffering. Leela was now just skin and bones. Her constant cries and curses on Desai and Mukherjee and even on me, day and night echoed in our ears. Patients in the neighbouring rooms and their relatives were also disturbed and dismayed.

Almost a week later, on December 31, a wardboy brought a bill (No 2899) dated the same day. What was most surprising was the amount of Rs 5,000 charged as operation fees for Desai and Rs 1,666, i e one-third of Desai's fees, for Mukherjee as his assistant. I was furious. I could not understand how Desai or the hospital could charge Rs 5,000 as operation fees when he had not operated at all. In fact, Desai had even disowned Leela as his patient. This was, I felt, not only unethical but outright cheating. I talked to the manager G P Sharma about this. D P Vyas, the



then administrator, now medical superintendent, was asked to inquire. A few days later, I was informed by Sharma that the hospital would drop this amount from the bill. However, this was not done till March 13, 1988, when it was changed and a copy was given to me. However, Bombay Hospital sent all the bills including this bill to the government of Rajasthan for payment without revising the amount. More shocking was the fact discovered by me at the end of December 1988 that the manager, Sharma was pursuing the government of Rajasthan to make payment of the bills including Rs 5,000 as fee for Desai, and continued to do so until March 1989!

A patient, Mrs Karnawat was admitted in the room opposite Leela. Her husband Sardar Singh Karnawat, a prominent chartered accountant in Bombay, advised me to make a complaint against Desai to the management of Bombay Hospital. By this time, I too, was very angry. So I made a written complaint, dated January 19, 1988, and requested Karnawat to pass it onto Bharat Tapadia, vice-president of the Hospital Trust. Karnawat was the income-tax consultant to Tapadia and he kindly obliged. For long I waited for a response from the management and reminded Sardar Singh also to contact again Bharat Tapadia. Then, on February 13 or 14, 1988, Anil Sanganeria, personally handed me a letter. To my utter surprise,it was not a response from the hospital management but a copy of a letter dated February 12, 1988 addressed by. Desai to S P Jain, chairperson of the Hospital Trust and to C G Joshi, executive director. I reproduce here the contents of the letter:

> I wish to bring to your kind notice the untruth and false statements that the above mentioned patient is making about me in relation to the treatment of his wife, Mrs Singhi.
> Mrs Singhi is NOT my patient and I was requested only ONCE by Mukherjee to examine and opine on her problem.
> I did opine, that since there was no other alternative for her advanced cancer a chance may be given by a surgical exploration.
> Mukherji never requested me to either do or assist him in this operation which he undertook on his own; neither has he requested me at any time (during her complications postoperatively) to see the patient.
> My medical ethics do NOT permit me to intervene or opine in other patients problems without a specific request from the attending doctor.
> It is, therefore, absolutely unjustified, if Mr. Singhi has complained to you about me or the care that I render to my patients.

Medical science is largely a matter of opinion and experience and I am not bound by any opinion anywhere else be it USA, UK or Japan.
I would also request the administration NOT to admit patients on my name when actually they are patients of other doctors like Mukherji or anyone else. The administration may investigate further into this episode to get the facts straight and not rely on the patients version alone.

### Attitude of Bombay Hospital

It was clear that Desai had decided to tell lies in order to save himself by implicating Mukherjee, his assistant. It also exposed his terrible ego. The letter blamed the hospital management for its policy or practice of admission, which he was aware of since many, many years, and was benefiting from it.

I met Sharma and showed him this letter. He had the utmost sympathy for my wife Leela and me. In fact, he was extremely helpful to me since Leela came to Bombay Hospital for the first time in 1977 for her treatment. He advised me to meet S P Jain. I took an appointment and met him at his residence. Luckily Joshi was also present. I narrated the whole episode to Jain and requested him to conduct an inquiry into it. But to my shock, Jain said, "Mr Singhi, I have spoken to Desai. I have also received his letter of explanation in response to your complaint. I am more than satisfied with that and therefore, I don't believe your story". I said, "Jainsahib, you are neither a child and nor am I a storyteller. My wife is on her deathbed in the hospital. She is Desai's patient who has been criminally negligent towards her and I want you to ask him to see her and take action against him". Jain replied, "If you want me to initiate any inquiry against Desai, you ask Mukherjee to give in writing the facts in detail of the entire case. You may otherwise go to the court." I was disappointed as well as angry. In an angry tone, I said, "Okay, Jainsahib, now I shall meet you in the court."

I returned to the hospital. I appraised Sharma immediately about my meeting. I wrote a letter on the same day addressed to Jain repeating what he had said and sent copies to Joshi, Mr S V Mazumdar, secretary of the Trust, and to Sharma. A friend of mine suggested that I meet Kisan Mehta, a well-known social worker. He told me that I should file a complaint with the Maharashtra Medical Council (MMC). Regarding a civil suit in



the high court, he said apart from being time consuming, it would also be very expensive. I returned disappointed because I had no money. However, I filed the complaint in May 1988 with the MMC.

I knew that going to court was not easy, more so when my opponents were going to be world renowned persons like Desai and a rich and powerful institution like Bombay Hospital. With Leela on her death-bed and suffering it was even more difficult to think clearly and act. I thought perhaps the best way was to first approach Mukherjee and get his position on the issue. I wrote a letter to him on February 19, 1988, enclosing a copy of Desai's letter of explanation. I also told him that if he did not give me the reply stating the actual facts of the incident, I would proceed against him too because the consent for operation had been given only in favour of Desai. I also sent a reminder dated March 24,1988. Mukherjee avoided replying for quite sometime. Finally, sometime in the first week of April, he gave me a letter which reads as follows:

Kindly refer to your letter dated February 19, 88 and subsequent reminder dated March 24, 88.
I being a student of P B Desai as well as his Asst did not want to get involved in the incident. However, it became obligatory on my part to clarify my position as my name has been dragged into the picture by . Desai in his letter dated February 12, 1988.
The facts are as follows:
On your return from US on November 28, 1987 I was called by you to see Mrs Singhi at your daughter's residence in Santacruz, first on November 29, 1987 and thereafter on other days. Since she been an old patient of CANCER since 1977 and treated by J C Paymaster and me in Bombay Hospital ever since, I too had been associated with her treatment in my capacity as an asst to Paymaster. After his retirement you had been consulting me as well as Paymaster. This time too as usual I examined your wife (Mrs Singhi) and started the treatment as prescribed by Greenburg of Sloan Kattering Memorial Hospital. Unfortunately she started vaginal bleeding on December 6, 1987 and I recommended hospitalisation. You accordingly got her admitted on December 8, 1988 in room No 1005 (MRC) of Bombay Hospital under P B Desai. (Mrs) S Jagirdar talked to me to refer the case to . P B Desai which I willingly did. In the meanwhile, all routine tests including CT scan were got done in the Bombay Hospital itself. P B Desai examined clinically the patient in her room No 1005 (MRC) and advised removal of the uterus. It is correct that the US Doctors had declared the case to be inoperable but on the basis of the CT scan report we all felt sure regarding prognosis. On your request I contacted

P B Desai on phone at his residence to operate the case himself. Maniyar, the House Surgeon also talked to him. He suggested to fix up the case of Mrs Singhi on December 22, 1987 when he was having another case already fixed up. My (AKM) conversation with P B Desai (PBD) on phone went on like this:

PBD- "You go ahead. Just take care of lung cancer."

AKM- "Sir, case is complicated. Has come from New York. They want you to do the operation."

PBD- "See me tomorrow in CST."

I met him on the MRC ground floor when he was in his car. He told me to take help of Hegde but I told him that the patient and her relation want you (Sri Desai) only to operate. Desai told "I cannot come on Tuesday - Wednesday. Keep it on Thursday. Fix it with Maniyar."

On Thursday I waited till 9 am. Hegde and Nagarkatti started thoracotomy in 1st Theatre. Desai came and entered into Ist OT. I took the case (of Mrs Singhi) in 2nd OT. Maniyar was with me. I opened the case on epidural anaesthesia. Rashmi Kotak was the anaesthetist. As soon as the abdomen was opened, a lot of adhesions ascitic were found all over. I sent Maniyar to call Desai. But . Desai was in OT No 1. Therefore I sent out myself and requested . Desai to come and see the patient (Mrs Singhi). When he came out of OT, he enquired, "What happened?" I told him that everything inside the abdomen is totally plastered and full of ascitic. But Desai asked only to close the case. He did not come to see Mrs Singhi. His response was poor.

I had no option but to close the abdomen and did needful and informed you outside the OT itself on 5th floor.

I am sorry, Mrs Singhi had to suffer unnecessary torture for so long. However, I am trying my best to look after her and God will help all of us. I am sorry I have to state the facts in writing because you have asked me to do so on the basis of P B Desai's letter dated 12th February 12, 1988. I hope this will clarify the matter and satisfy you.

Leela was discharged from Bombay Hospital on April 4, 1988. Mukherjee accompanied her to Jaipur and handed her over to Dr P K Wanchoo, the oncologist and head of the department in Government Hospital, Jaipur. Wanchoo had been looking after Leela in Jaipur since 1978 and had become a great family friend. He examined Leela and her entire medical record. He felt very sorry for her because in his opinion also, this operation was absolutely uncalled for. However, he started attending to Leela regularly. The intestinal fistula continued oozing liquids at least 10-12 times a day. Two private nurses had to be engaged to attend to Leela day and night. Leela's condition did not show any improvement. Her continuous cries made everyone miserable, including the neighbours. She was cursing loudly Desai and also Mukherjee.



I retired on February 28, 1988 from government service. Although I had a number of attractive offers to join private organisations, the very idea of earning while having Leela on death-bed was anathema to me. I sat 24 hours beside Leela. Her pain was intense now. Leela's intake of food had almost stopped. She had completely shrivelled up. A friend suggested homeopathy to relieve her pain. I had no objection. Wanchoo, who had already expressed his helplessness in this regard, also approved. That friend brought a homeopath, Raj Mehra. He examined Leela and said that homeopathy could reduce her pain and, perhaps, also help in closing the fistula. The treatment was started in September 1988, and what a miracle. In a week's time the oozing diminished. The number of dressings came down to three or four a day. Leela started taking some wheat porridge with green vegetables. The juice of a pomegranate everyday was also given. She was now feeling a little better and was also looking better. We were all very happy. Leela began to move about a little in the room and came out on the lawns also. Our hopes rose. Even Mehra felt the fistula may possibly completely close. If this happened, Leela would be all right for some time at least. However, God willed differently.

I had filed a FIR with the Director General of Police in Bombay against Desai for his criminal negligence. I was constantly thinking of filing a civil suit also in the Bombay high court for damages. I consulted a lawyer, Girdhari Singh Bafna, in Jaipur. He examined the papers and advised me to issue a legal notice to Desai, Mukherjee, (Ms) Talwar and to the Trustees of Bombay Hospital. Accordingly, a notice dated June 1, 1988 was sent to them all, asking them to send their replies within a month.

A reply came only from the doctors. It was dated June 22, 1988, and signed by an advocate, C K Jaisinghani,on behalf of all the three. I was surprised to find that this reply while defending Desai was putting all the blame on Mukherjee. I could not believe, this reply to be genuine. So I wrote a letter to Mukherjee sending him a copy of the reply. Soon came a letter from Mukherjee saying he had not sent any reply to my legal notice. He did not even know Jaisinghani leave alone his

authorising him to send any reply on his behalf. It became clear to me and my lawyer that it was a conspiracy to implicate Mukherjee and to save Desai. Mukherjee said he was taking action against Jaisinghani for cheating.

Meanwhile Leela had been getting weaker everyday. She knew that her end was approaching fast. She was worried not about herself but about me. She felt, Desai's injustice would never allow me to live in peace. Eventually Leela persuaded me to go to Bombay to file the suit. She promised to talk to me everyday at 8 am in Bombay. So I came to Bombay with a personal letter for A G Noorani, the renowned lawyer and writer. I met Noorani at his residence. He had already seen my case file and had found the case quite maintainable. He suggested the name of a good senior advocate, J B Chinai, whom I met in the high court the following day. He heard me out and said while the case was sound, it would take at least 10 to 15 years to be decided and, secondly, it would be expensive. "I feel there is no point in filing a suit."

But I wanted to file the suit before the limitation period was over, i e before December 21. Chinai took three days to draft the plaint. M/s Satpute and Company, were appointed as the solicitors. 'nce the plaint was ready, I was told to get it signed by Leela also. I reached Jaipur on December 18. It was a Sunday and I had to send the plaint back duly signed the following day. The collector and the district magistrate of Jaipur, Rakesh Hooza, a friend, attested our signatures. On December 21, the case against Desai, A K Mukherjee, Inder Talwar and all the trustees of Bombay Hospital was filed in the Bombay High Court vide No 1101 of 1989.

### Leela's Last Moments

Leela's agony was hard to see now. The homeopathic treatment which was providing some relief earlier was no longer effective. Against the odds created by the ill-advised operation, Raj Mehra's valiant homeopathic efforts were not successful. Leela saw her inevitable end approaching. She dictated the following sentences for Desai:



> On account of your inhuman and dishonest behaviour, I have been confined to bed for the last one year and crying and shouting all the time. Now, in next two-three days, of course, I will go away to God. In every breath of mine, I have cursed you. God will make them come true and you and your wife will suffer in the same way as my husband and I have suffered. You have murdered me altogether. God will never pardon you.

Just four days after dictating this letter Leela passed away. It was 12 oclock midnight. Raj Mehra, her homeopathic doctor, was there and holding her hand. His eyes were wet, face grim. In the last so many months, Leela had taken him as her brother and reposed more faith in him than in anyone else. Our two daughters, our permanent and constant care takers, Ram Bharos and Ajit Singh, and I were standing around the bed. Two or three heavy breathes, a few jerks, she opened her eyes only once, looked around and bade her final good bye to all. The nurse, Urmila, who had been attending her for the last 10 months and whom Leela had treated as her third daughter, was there, too.

Leela had really gone, forever. While silently crying at the greatest personal loss in my life, I felt confused. Was it an end of my loving companion or an end to the intolerable torture that she had been suffering from? Should I be crying or thanking God for relieving her from the pain imposed upon her? She was great, a generous soul, full of compassion for others, sacrificing and above all, sweet. I can never forget the remaining hours of that fateful night of February 25-26, 1989. We carried Leela's body on our shoulders to the *shamshan* ghat. More than 1,000 persons had accompanied us. A gathering that made us proud of Leela in spite of the grief of her passing away.

A very strange thing happened on that day. After coming back from the funeral, I went to take a bath in the open lawn of our house. I had placed my spectacles nearby and after the bath I was shocked to find that they were not there. All efforts to trace them failed. I remained without glasses for a full week before the new ones were made. Missing my glasses made me realise that Leela was my eyes and with her gone, the old specs also left me. This forced me to see for a week the world with naked eyes. This state reminded me that as soon as my new glasses were procured, I

was to work for the fulfilment of Leela's last wish, to ensure that her tormentor, a naked murderer in the guise of doctor, was duly punished.

Suddenly I found that I was no longer confused. The listlessness and lifelessness brought about by Leela's departure was gone. I was still sad, but I knew what I was supposed to do. It dawned upon me that Leela had not taken a selfish promise from me to get vengeance. Her curses were in order to steel me for a fight, and she wanted me to take up this fight not simply for her suffering but to ensure that others were not made to suffer like her by unscrupulous, irresponsible and arrogant doctors. I knew that the best tribute that I could pay to her soul was by relentlessly pursuing her last wish in such a way that not only her tormentor doctor was punished but also the patients/people were empowered to fight against such doctors.

While Leela was fighting pain and at the same time giving me courage to fight, Desai was making frantic efforts to 'kill' the case before the MMC during the preliminary hearing. The Medical Council holds preliminary hearing in order to decide the existence of *prima facie* substance in the allegations made by the complainant. Interestingly, he had told Sudhakar Sane, president of the council, not to take cognisance of my complaint, rather reject it, in the first instance. However, Sane could not help because it was not possible to do so legally. Then, Desai had refused to appear before the Council simply because he considered it below his dignity. On December 23, 1988 he had written to Sane:

> I sincerely hope that as the president of the esteemed Maharashtra Medical Council, you will please take a stand and realise that my presence for the said inquiry, is, in fact, quite unnecessary. In my 30 years of professional life, I have not committed any breach of professional ethics and very candidly speaking I shall be thankful to you if you could please understand the situation and help to avoid my presence at the Maharashtra Medical Council.

In another letter dated May 25, 1988, he further wrote in a threatening language to the Registrar of the Council:

> If, however, any action of the council goes to sully and tarnish my professional reputation and prestige, and toil of 30 years, you will appreciate that I will seek every legal help to protect my most privileged cherished possession which is my professional standing and prestige. After holding out this threat, he exhorted the council to act as a protector of the profession by saying that, I know that the Maharashtra Medical Council has a moral obligation to the community but I also know that the Council, more importantly, has to protect and safeguard the interests of the medical professionals who are now adays being increasingly subjected to unnecessary innuendoes and false charges, which are merely expressions of an anguished and troubled mind due to prolonged illness beyond anyone's control.



The matter before the MMC was taken up for preliminary inquiry after Leela's death. I was still in Jaipur, and was informed by a friend that the Council had called Sachdeo, medical director, and C G Joshi for their statements on oath and that the MMC was likely to reject the complaint. I was upset. I decided to send a copy of the letter which Mukherjee had given to me about the entire episode. I posted it under registered AD. It reached the Council in time. At their next meeting, they called Mukherjee to give his statement and to corroborate the contents of his letter. Mukherjee did so. The MMC was *prima facie* convinced of the charges I had levelled against Desai and issued a notice dated May 14, 1989 to him along with a statement of allegations.

It was really a great victory, particularly because the Council consists of only doctors. In the Medical Council normally the case is rejected in the preliminary inquiry as the patient is not allowed to be represented by a lawyer and the doctors consciously or unconsciously show bias in favour of their professional colleague. Thus even a preliminary *prima facie* recognition of violation of ethics by a professional body is significant. The press took it up and the news created some stir in the medical community. No one had thought that a doctor of the eminence of Prafulla Desai could ever be even charge-sheeted. Desai also went to the press with his version. His plea was that Leela was never his patient although she was admitted under his name and care. According to him, it was the policy of the hospital to admit patients only in the name of senior surgeons.

## MMC Inquiry

The regular case hearing into the charge-sheet/notice started from July 1, 1989. I engaged S Radhakrishnan as my advocate,

God-fearing, very polite and intelligent. His name had been recommended to me by Kisan Mehta. The proceedings went on for more than 30 months a very long period, easy to exhaust anyone's patience. I had but to bear it. It was a huge expenditure too. Several people from Bombay Hospital were called as witnesses. I had to produce a large number of documents as did Desai. He was always present during the inquiry.

During the course of the inquiry, Mukherjee revealed two facts which shocked all the members of the MMC. One was that Desai had shown utter negligence towards patients even in other case earlier. Mukherjee named these patients and Desai did not deny this. Another was that Bombay Hospital admitted patients in the names of such doctors who had either retired or had expired long ago. Such as Paymaster who had retired and Arthur DeSa who had expired nearly five years ago. The cases of such doctors were operated upon by the juniors who sometimes got their fees and sometimes did not.

Once all the witnesses were examined and evidence recorded, Desai was asked to give his statement of defense. He maintained that Leela was not his patient although Bombay Hospital admitted her under his name and care. He said it was the policy of Bombay Hospital and he could not be held responsible. And that although the bill for Rs 5,000 as operation fees in his name was made by the hospital staff, he could not be held responsible. He, however, had not taken any fees. Then at the end of his statement on oath on March 31, 1990, Desai produced 'original' operation register of Bombay Hospital in support of his contention that Leela was not his patient and that he did not operate on her. In this register, only Mukherjee's name was mentioned as the operating surgeon.

Sane asked my lawyer to begin his arguments on the same day but Radhakrishnan prayed that he wanted to study the register which Desai had presented before the MMC. Next day, we produced xerox copies of another register of operation maintained by Bombay Hospital. All the members in the presence of Desai and his counsel, T Andhyarujuna, examined this and after comparing it with the register presented by Desai, were shocked



to find the discrepancies in the two registers of operations. Both appeared to have been maintained by Bombay Hospital.

A detailed comparison was made of the two registers. It was clear that in the register presented by Desai, (i) several columns were left blank, (ii) the entire register had been written in one person's hand, (iii) there was no signature of the sister-in-charge of the OT on that day as the normal practice is, (iv) the register had nobody's signature anywhere and (v) the information entered in the various columns of this register was materially different from facts, for example see the Table.

**Table**

| Col No | Original register of Bombay Hospital presented by Desai | Xerox copy presented by Singhi of Register of Operations |
|---|---|---|
| 1 (SL No) | Nil | 294 |
| 7 (Surgeon) | Mukherjee | P B Desai |
| 9 (2nd Asst) | Nil | Illegible |
| 11 (Anaesthesia) | GA | Epidural |
| 12 (Duration) | Nil | 10.15 a.m. to .. |
| 13 Class | AC II | Ist. |
| 14 Major/minor | Nil | Carcinoma Cervix |
| 15 Nomenclature of disease | Nil | CA of Cervix |
| 16 Remarks | T/C Rs 1500 | Nil |

The members of the MMC at this stage asked me as well as Desai to go out of the meeting hall along with our advocates for some time. The members discussed the matter among themselves and finally decided to ask Bombay Hospital authorities to explain the various anomalies found in the registers.

A reply dated April 16, 1990 was received by the MMC from the Bombay Hospital where it was stated that, "The operation register produced by the Hospital is Register-I, which gives the full details of the operating surgeons and their assistants, besides all other relevant details. This register gives the consolidated information regarding the operations performed in the operation theatre. The xerox copy referred to by your letter is registerIV, ..... the said register is found missing from hospital records. We have every reason to believe that this

register has been unauthorisedly and illegally removed by an interested party."

The MMC at its meeting held on April 21, 1990, examined on oath Joshi and Amar Bahadur Singh, in respect of these registers and their maintenance. The members asked why a police complaint was not made about the missing register and why the MMC was not informed in the beginning about the four registers maintained by the hospital. The hiding of this fact by the hospital created doubts in the minds of many a member. The statements on oath made by the officials were also found to be ridiculous. For instance C G Joshi said, "The clerk changes his clothes and goes inside the theatre to ascertain the facts regarding entries in the register of operations." Practically, all the members of the MMC had a hearty laugh at this 'revelation' made by the senior most executive of the hospital.

Finally on October 27, 1990, the two advocates, Radhakrishnan and Andhyarujana, argued their respective cases. It was decided that both the sides would submit their written statements of arguments so that the members of the MMC were able to apply their minds properly and draw conclusions to pronounce their judgment.

The Council gave its historical judgment on January 13, 1991 and pronounced it in the presence of Desai, myself and both counsels. Mukherjee was held to be innocent in the whole episode. He had merely followed Desai's instructions. The Council declared Desai to have been found guilty of "professional misconduct" but by way of punishment issued only a "very strict warning".

I must mention the contribution of two doctors in making my efforts with the MMC successful. A K Mukherjee was always helpful. His courage to stand up against his own boss and one time teacher, Desai and against his employer, the Bombay Hospital, was really admirable. He staked his career for ethical values and the truth. It is correct to say that, unlike many cases, my case was taken up for a full-fledged inquiry and a bold judgment given by the MMC was to an extent due to the truthful



testimony given by another doctor. Perhaps without his support I would not have succeeded in my complaint before the MMC. Another doctor who stood by was J C Paymaster. This former director of Tata Memorial Hospital and later head of the oncology department at the Bombay Hospital, constantly guided me in preparing my case.

In fact the MMC had given two judgments on that day and in both, Desai was found guilty but in effect let off with only a warning. The second judgment was in another complaint against Desai filed by me and another person. It was about his allowing the *Illustrated Weekly of India* to publish his photograph on the cover page and his article in that magazine. It was Paymaster who gave me a copy of the *Weekly* of April 20, 1989. The article dealt with the activities and achievements of Tata Memorial Hospital over last so many years. I was shocked to find that even the name of Paymaster, let alone his contribution to the Hospital and humanity's fight against cancer, was not mentioned. While the Government of India conferred upon him the title of Padma Vibhushan for his services, Desai, his own student and successor to the post of director, did not deem it necessary to mention, even once, Paymaster's name in the entire length of the article.

Paymaster when questioned by me on this point, only shrugged his shoulders and gave me a group photograph with Desai standing just behind him and Borges. When I filed a complaint of professional misconduct dated April 28, 1989 against Desai before the MMC, I also presented a photocopy of this group photograph. The MMC found Desai guilty of professional misconduct. The MMC also declared Desai guilty of violating the code of medical ethics in respect of his photograph published in the magazine. He was thus issued additional written warnings in response to this complaint.

The medical world in India was shaken. It was, perhaps, unbelievable for many that Desai might have behaved like this or that doctors could really conduct themselves in this manner. The MMC inquiry took more than two years. This period was too long for me, for my daughters, sons (sons-in-law), relatives

and friends. Unfortunately, not one of my friends had supported me. They all had sympathy, but no spirit for action. None of them thought that it would be possible to take action against Desai, who holds such a powerful position on the one hand and has the support of politicians as well as the capitalists lobby in Bombay Hospital. Truly, I myself had grave doubts about the impartiality of the Council given the background. I only hope that the council members will continue their good work and in other cases give stringent and thus real punishment to the guilty doctors. Given the state of the medical profession today, only by doing such work will the Council be able to salvage the prestige of the profession.

During the period of MMC inquiry and thereafter, the press all over the country, particularly in Bombay, had really shown great interest and given it wide coverage. The Bombay group of Medico Friend Circle, a national level registered group working on health issues also took up this case and created awareness among the people at large by organising two press conferences on my case alone, by publishing articles on the subject and by raising the issues of medical malpractice and unethical conducts of doctors at the national level. Several correspondents representing important daily papers such as *The Times of India, The Daily, Gujarat Samachar, Navbharat Times, Mahanagar, Jansatta* (Bombay) and *Sandesh* (Ahmedabad) and *Rajasthan Patrika* (Jaipur) gave wide coverage to this case. The correspondents of various magazines such as *Island, Bombay* (Bombay) and *The Sunday* (Calcutta) also published elaborate reports after personal interviews with me and Desai.

People in general and the press in particular have been asking why only a warning was given to Desai considering the gravity of the offense. Definitely, it warranted cancellation of his license, if not permanently, at least for a short period. I have no answer to this question, but, perhaps, because Desai wields enormous power he could get away with such a light punishment for a proven grave misconduct. It is also interesting to note that the members of the MMC did not write their judgment in detail - specific to each of the charges levelled in the notice of inquiry. I requested the president of the MMC through my counsel to



give detailed judgment vis a vis each charge. After great persuasion, the MMC sent me a letter dated April 7, 1992. This letter states that, "The MMC arrived at the verdict that P B Desai was guilty of allegations made against him in the charge-sheet of inquiry presented to him." In other words, it could be interpreted that all charges made against him were found to be true. Thus, if this letter is taken as a part of the verdict given earlier by the MMC, then it is clear that he was found guilty not only of professional misconduct but also of other charges, namely cheating, forgery and criminal negligence. The members of the MMC, who are all senior doctors, could not dare to antagonise their own fellow doctor who enjoyed prestige, power and money, and therefore could not mention them openly in the judgment. In any case, had they mentioned that he was found guilty of so many grave charges, they would have found it impossible to justify such a light punishment pronounced by them.

Although many may feel that a warning is no punishment of any consequence to a doctor who committed such unethical acts, the context in which it was given made it a historical event. The Medical Council has punished many doctors in the past in more severe way. But invariably such punishment came either after the courts had found the doctor guilty or on some other actions of doctor like giving undue publicity to oneself or for advertising. But for the first time, in response to a complaint filed by a patient's relative about the doctor's conduct during treatment was a doctor of international repute found guilty and punished.

After the victory in the MMC, in 1992, there was an unexpected turn of events. It shows how people are vulnerable to the power of the medical profession, and thus merits a mention. I am told that in 1992 Mrs Paymaster fell ill and was taken to Tata Memorial Hospital for treatment. She remained there for about a month and Desai looked after her well. After this incident, Paymaster tried to persuade me to withdraw the civil suit against Desai. Through Kavarana of Tata Memorial Hospital and A K Mukherjee I was told that in return, Desai would offer a verbal apology and a few lakhs of rupees as compensation. Kavarana even called me to Willingdon Club and discussed the whole

matter for more than four hours. The late Jeevaraj Mehta of Bombay Hospital Trust also tried to arbitrate in the matter.

I was both surprised and hurt. All my sympathisers knew very well that I wasn't fighting for prestige or monetary gain for myself. Whatever I have done so far is open to public knowledge. The people and the press have sympathised with the cause. It would be a betrayal of their trust if I withdrew my case without making it publicly known. How could anybody think that I would accept a verbal apology in private? I refused. I said that apology must be in writing. Money was not an issue. I told them that the amount paid as compensation would go for charity. My point was, and will remain so, that I am accountable to people, the deal must come before them. This was not possible unless the apology was in writing.

### Criminal Case

Till the case was before the MMC, I did not have enough time to regularly pursue my FIR lodged with the Maharashtra police on September 9, 1988. But I had managed to have a few meetings with Sattegiri, the chief police prosecutor, S Ram Murthy, the police commissioner of Bombay and the concerned Deputy Police Commissioner. Unfortunately, the police failed to even register my complaint and at one point, wrote to me that it would wait for the judgment of the MMC before filing a criminal case in the court. In fact, the police also did not investigate the matter with necessary sincerity. As soon as the MMC gave its 'judgment', I sent a copy of it to the police expecting that now as promised, they would act systematically. But that was not to happen. For about five months after, for some mysterious reason, the police did not take any action in the matter. Finally, it was only on the orders of the police commissioner that on May 14, 1991 that the police filed a criminal case in the Esplanade Court, Bombay under Section 338 read with Sections 109 and 114 of the IPC. But they did not do this without playing their customary mischief. In this case, to my utter surprise, the police had also made Mukherjee an accused! In my FIR to the police, Mukherjee's name wasn't even mentioned.



Anyway, the court fixed January 8, 1992 for the hearing of the case. But before the date of the hearing, he filed a writ petition before the high court to obtain a temporary stay on the hearing of the criminal case. Here the public prosecutor (PP) played his game. One would normally expect him to oppose such a plea for the stay. But he did not and the high court granted the stay.

I am a retired IAS officer. Such a gross failure in duty by a public servant perturbed me a lot. I met the police commissioner who advised me to meet Moray, the law secretary of the government of Maharashtra under whose jurisdiction the work of the PP comes. I met him and appraised him of the full details of the case. He very kindly, issued an order to change the PP and asked Pege, the chief public prosecutor, to attend to this case and to get the stay order vacated. Pege entrusted the case to his deputy, Lambay, who really took keen interest and moved an application followed by an affidavit of the police before the high court in order to expedite final disposal of the writ petition filed by Desai. Eventually, the stay was vacated on March 31, 1995.

As mentioned earlier, a civil suit was filed by Leela and me on December 20, 1988, the last day of the limitation period, in the Bombay High Court against Desai, Mukherjee, Inder Talwar and the trustees of Bombay Hospital. I had claimed an amount of Rs 23.75 lakh as damages and as a result, I had paid Rs 15,000 as court fee at the time of filing the suit. I haven't filed this case to get money for myself. If the compensation is ever granted by the high court, the entire amount would go to charity. For this case is not against a doctor named P B Desai, but against the whole gamut of medical malpractice and the commercialisation of this noble profession.

* * *

Five years have elapsed since I filed this case. My experience of the judicial system has convinced me that no citizen in our country should ever dare to approach any court for seeking justice unless he has lost his senses. A meagre number of courts on one hand and a large number of posts of judges lying vacant

on the other, have seriously hampered administration of justice. Further, what will invariably shock you is the all pervading corruption, nepotism and politicisation of the judicial system. The legal profession has also degenerated in its ethical character. The poor litigant may momentarily feel happy to see his or her case on the board before a judge and keep sitting in the courtroom for hours with a hope that the matter will be heard. But alas, such hopes are soon belied when in the middle of the day the board is discharged or even at the end of the day the matter does not come up for the hearing. In some cases the plaintiffs have grown so old that they are not able to present themselves in the court or some have even died. The higher judiciary is today more busy with commissions of inquiry, election petitions, scams and scandals (even these cases are not completed on time) that it has hardly any time to listen to the cases from general masses.

Way back in 1955 while joining Civil Services I had taken a vow that after my retirement I would not earn a single penny and devote my retired life reading, writing, teaching or fighting for social causes. I had also decided that I would live only on my pension. Leela had always supported me on this issue. Since my retirement I have not earned anything but Leela is not around to be with me. However, before going she gave me a social cause to fight for.

While visiting the court I have met some litigants whose cases are pending for the last 15-20 years. I am therefore not so sure about my suit which is only five years old. My advanced age (65 years) with a cancer in the urinary bladder and retinal problems in the eye make me highly vulnerable and insecure. In this state I have petitioned the court persistently to expedite my case. This has given me some hope as so far for three times different judges, including the Chief Justice, have passed orders for the expedious hearing of my case. Such an order was given by Justice Suresh (1990), Justice A Sawant (1991) and Justice Sujata Manohar (1992). It has so far appeared on the board of the Court about 200 times. It has travelled to judges such as Justices Variava, I G Shah, Dhanuka, Rane, Cazi, Jhunjunwala and to Variava again. Of them only Justice Cazi could hold a few



hearings and framed the issues in 1992 but could not commence final hearing. Like judges, my advocates also went on changing. J B Chinai, S Radhakrishnan, P L Nain, Vasant Kotwal, Girish Desai, Aspee Chinai, Deepak Merchant, C A Kaveria, etc provided very useful services from time to time. The changes primarily came about due to procedural delays.

In 1993 it came before Justice Jhunjunwala and the hearing in the case could have started but for an unexpected development. Two days before the scheduled date of hearing on July 23, 1993, an unidentified person claiming to be my well wisher telephoned me. He asked me to withdraw the case and accept Rs 5 lakh as compensation from Desai and the Bombay Hospital. He further said that if I failed to accept this offer I would lose my case as Justice Jhunjunwala was recently operated upon in Bombay Hospital. I tried to contact my solicitor but could not do so. I was desperate. I knew that I had to do something. Hence I decided to write a letter to the Chief Justice. I simply narrated the incident and requested him that the case might be transferred to some other judge so as to avoid any embarrassment to Justice Jhunjunwala.

The following day, July 22, Justice Jhunjunwala objected to my writing the letter directly and for not submitting it through my lawyer. I could not understand the logic of his argument. After all I am the plaintiff and not my lawyer! The lawyer is engaged by me and is supposed to work according to my instructions. In the event of his non availability what was wrong if I wrote the letter myself? He asked me to get my advocate next day. So on July 23, my advocate came and as was expected pleaded that he did not know about the letter at all. The judge then asked me to withdraw the letter and that the hearing would start only after withdrawal. I was firm. I told him that I had only put on record the contents of a telephone conversation I had. I also assured him that I had not expressed lack of faith in him. So I suggested that the letter should stay on record and the hearing should proceed. But this was not acceptable to him. I did not relent either. So he dropped my case from his board once and forever. The order to this effect passed by him runs into several pages and makes interesting reading.

The case now went back to Justice Variava. He passed an order on August, 1992 to start the hearing but he was suddenly assigned special cases of election petitions and the security scam involving Harshad Mehta. So it was only in 1993 the arguments started.

Desai's advocate Sale Doctor and Bombay Hospital's advocate strongly argued to get the case dismissed on the ground that the plaint was based on the Law of Tort and so it dies naturally after the death of plaintiff, my wife Leela. My advocate S Radhakrishnan argued that the case was also under the Law of Contract and thus, could not die on account of the death of Leela Singhi. On September 3, 1993 Justice Variava accepted that the plaint also contained issues which were contractual in nature and in any case I was still around, the second plaintiff and heir to my wife.

I thought that this order had set the controversy at rest. But Desai has filed an appeal in the Bombay High Court against Justice Variava's judgment. This is what happens when somebody powerful wants to delay justice. Whereas the issues related to facts of the case are not even heard by the court, lengthy arguments and appeals eat away precious time only in interpreting the law. Fortunately for me, the appeal was eventually dismissed, and on our consent, Desai was allowed by the court to withdraw it.

It is difficult to predict the final outcome of these two cases in the courts but one thing is certain that this case has drawn the attention of the entire country and has exposed the medical profession which, of late, has become horribly corrupt and has lost its noblestature.

Leela has gone, she had to go, but the way of her going has left deep scars on my mind and wounds in my heart. These scars and wounds cannot be healed by anything except by people's collective fight against the total commercialisation of medical care. I am, therefore, now more concerned with the 'fight' than the final outcome of my cases. I have declared more than once that the entire amount that I may get as compensation will go to



charity. One such charity Leela had suggested in her last days was to establish a Free Cancer Relief Centre for Terminal Cases in Rajasthan. I have no personal animosity with Desai. Thus, a cancer specialist like Desai upholding the ethics and the nobility of the medical profession is precious to suffering humanity. That is why my honest gesture to a reformed Desai would be to take over as director of the cancer hospital in Rajasthan, as and when I am able to fulfil this dream of Leela's. I will always pray that God bless him with sensitivity to human miseries and me with sufficient strength to fulfil Leela's dream.

# *Medical Brotherhood*

## Raghunath Raheja

My wife Bhagwati had been suffering from diabetes for over 20 years and was on oral medication. In mid-1989, she developed high blood pressure and was treated for it. Her condition improved. But in October, her health suddenly took a turn for the worse.

It was October 18 and the time was around 10 pm. We had just finished dinner and were watching TV when suddenly my wife complained of nausea and rushed to the wash basin. She threw up and had an attack of breathlessness with a bout of coughing which went on for quite sometime. When her condition did not improve we called a near-by doctor who gave her an injection and told us to admit her to Nanavati hospital immediately. The doctor was kind enough to take us to the hospital in his car. Bhagwati was admitted to the ICCU and remained there for a week. As her condition became stable, on October 26, she was discharged from the hospital. At the time of discharge we were advised to see the cardiologist attached to the hospital, Dr D B Pahlajani, at his private clinic after a week.

A week later, on November 2, 1989, we saw Pahlajani at his clinic at Santacruz a western suburb of Mumbai. He took an electrocardiogram (ECG) which indicated inferior wall ischaemia . He recommended an angiography. When I discussed this with my friends, they told me that if we agreed to the angiography, the doctors would next recommend bypass surgery. It all happened so suddenly and being lay people we needed time to think. I told Pahlajani that we would think it over. But before any action could be taken, my wife had a second attack of breathlessness, similar to the previous one, on November 22, 1989, at 11 in the night. We called the same doctor who had attended on her earlier. This time, too, he gave her an injection and told us to admit her to a hospital. And so at 11.30 pm, she was admitted to Nanavati from where she had been discharged barely a month ago.



The next day Pahlajani examined her and told us that we had taken a great risk by not going in for angiography. He warned that something worse could happen if we delayed it any further. We immediately agreed and the angiography was done on December 1. After seeing the angiogram, Pahlajani informed us that an angioplasty would have to be done and in the event that it failed, we would have to go in for a bypass. He suggested the name of Dr Sharad Pandey for the surgery.

The same day Sharad Pandey, one of the surgeons at Nanavati Hospital visited her and after leafing through her papers said that in her case angioplasty would not help, so it was better to go in for bypass directly. He assured us that there was nothing to worry about. It took him only five minutes to take this decision which was to affect our lives in a big way. Surprisingly, Pandey did not consider it necessary to examine her again any time before the operation.

December 7,1989 was the date fixed for surgery and she was operated upon by Pandey. She was taken into the operation theatre at 9.30 am and around 5.30 pm the doctors informed us that the operation was a success. We were elated, unaware of the events that would follow.

### Doctors' Profound Silence

After the operation the doctors told us that her condition was improving satisfactorily. However, she continued to experience chest pain. Two of her left hand fingers (the ring finger and the little finger) became numb. The wound on her thigh from where a vein had been taken for surgery showed no sign of healing though the wound on the leg from where also a vein had been taken had healed within a few days. We informed the two doctors, Pahlajani and Pandey, as well as the doctor on duty about this and continued to do so till the day of her discharge, but all three of them said there was nothing to worry about, and her condition would improve.

On December 17, two days before her discharge, my wife had severe pain in the chest. We informed the doctor on duty who

took an emergency ECG and told us nothing about it. On December 19, 1989, at the time of discharge, we were given a discharge card and were told that we should see Pahlajani at his clinic after a week. No instructions either written or oral were given about check-up or after care. All the doctors advised that she should get regular exercise by walking. When we inquired about the repeated occurrence of chest pain, the doctors said that this was a common complaint in postoperative cases and there was nothing to worry about.

As part of the followup we visited Pahlajani a week later, ie on December 26. After examining her, he took an ECG and for the first time wrote that she had "old antero septal infarction". We did not understand the term. He did not tell us that it meant heart attack. Nor did we know or were told when it actually took place. He should have known it as she was under treatment at the Nanavati Hospital from the beginning. We learnt about the heart attack only after her death. Pahlajani had been treating her since October 18, despite that he never once told us if and when she suffered a heart attack. He did not tell us on that day too. On the contrary, he said everything was all right and even advised the patient to get regular exercise by walking to ensure circulation of blood.

Ironically, that day he suggested that we take her to the nearby temple. He also advised us against carrying her up the three floors to our flat in a chair and insisted she should be made to walk up the three flights and also take a walk in the compound. Fully trusting him, we took her to the temple that evening and made her climb the three floors. Her breathlessness increased thereafter.

On January 1, 1990, she again had an attack of breathlessness though less severe than the previous ones. Also, the stitches on the wound on her thigh which had still not healed, opened up. So we took her to the OPD of Nanavati hospital to consult Pahlajani. However, on reaching the hospital around 10 am we learnt that he would not be attending the OPD that day. We spotted Pandey and told him about the problem. He said he had a bypass surgery to perform and told us to come back at 5 pm. We told him that since she could not climb three floors, we would not be able to go home and come, so we would wait in the hospital itself.



From 10 am we waited till 6 pm for him. She was lying on a bench and I sat beside her. At about 6 pm we saw Pandey leaving the hospital. I rushed to him and reminded him of his promise to see her. He said he had some appointments and hence could not see her, but his assistant, Dr G Kubal, would examine her after sometime. Kubal examined her at 8.30 pm after a wait of 10 hours. Perhaps a healthy person could have withstood the strain of this long wait, but for a person under postoperative care it was just killing. Both my wife and I put up with this torment as we were helpless. Finally, at 8.30 pm when Kubal examined her, he did not suggest any treatment for breathlessness, but said to 'wait and watch'. He however, called her on January 5, for restitching the wound, and did it.

On January 9, she again experienced severe chest pain four times in the morning. After our last long wait and suffering at the OPD of Nanavati Hospital, a private hospital, we thought that it would be better to take her to doctor's private clinic. So we took her to Pahlajani's clinic. He took an ECG and told us there was nothing wrong. It was after her death that we learnt that the ECG had shown an old infarction but he did not tell us about it. He told us nothing was wrong and advised her to take 'sorbitrate' when needed. When we asked him about the attacks of breathlessness, he prescribed 'angispen'. He neither suggested hospitalisation nor any precautions to be taken.

However, Bhagwati continued to suffer. Pahlajani's medicine had neither stopped her chest pain nor her breathlessness. Yet we decided to give his treatment a try. But with each passing day, no improvement was observed. We got terribly worried. We were not able to understand why she was suffering in spite of the surgeon telling us that the operation was successful and the physician constantly reassuring us that there was nothing wrong with her.

Ten days after meeting Pahlajani we lost patience. But where to go? We knew it was no use going to any new doctor. Our best

chance was with doctors who had been attending her. Since Pahlajani had repeatedly said that there was nothing wrong with her and since Bhagwati's suffering was so acute that we were prepared for her possible hospitalisation we decided to try our luck with the Nanavati Hospital. Fortunately January 19 was Pandey's OPD day in the Nanavati Hospital. We thought that on OPD day he would not be operating and would be seeing patients.

So in spite of our last long wait for Pandey at the Nanavati Hospital, we went there at 2 pm in order to have her examined by him. He was not there. Again we sat there on the bench waiting for him to arrive. After waiting for two hours, Bhagwati was feeling very tired. She was also having pain. I was exasperated. I mustered strength and again approached the junior doctor at the OPD. The doctor told us that Pandey would not be attending the OPD that day. It was a big shock. This should have been announced beforehand. How could the doctor and the hospital be so callous that nobody bothered about the waiting patient? We were now left with no choice. I asked the junior doctor to examine Bhagwati. The junior doctor on duty examined her and advised continuation of treatment as prescribed by Pahlajani. I was disturbed. I asked him that if the treatment prescribed was all right why was she still suffering. We insisted that he must do something. So he prescribed her one more tablet, but when we enquired with him we found that it was to treat her gas trouble.

### Patient Abandoned

Of course we were not satisfied. We thought that given the serious condition of Bhagwati, if it was not possible for the junior doctor to suggest a new line of treatment, at least he should have admitted her in the hospital. Our last chance perhaps was with Pahlajani. So we took her to his clinic. But Bhagwati's luck was running out. We were told by his typist that he had gone out of station for a week and had not returned. There was no stand-by doctor in his absence.

This was another shock. One eminent doctor had no time to attend OPD, another was out of station without appointing a



competent doctor to look after his patients. Our anger and frustrations had by now completely tired us out. Bhagwati said that she would prefer to suffer at home rather than on the bench of the OPD or in the autorickshaw. In any case we did not have much choice. So we came back home and I prayed to god to take care of Bhagwati.

Now we had no other choice but to wait for Pahlajani to come back. But fate had decided otherwise. After two days, on January 23, at around 7 pm I entered the house as usual. The door was open. I saw panic in the house. I rushed to our room. Bhagwati was seated on the bed. She was having trouble breathing. My children were standing around the bed. They were giving her some medicine. I inquired from them about what had happened. They told me that immediately after she had come out of the bathroom, she was having difficulty in breathing and severe chest pain. They had given her sorbitrate but it was not having any effect. They also told me that they had gone to call a lady doctor from the nearby building but she had refused to come. She had told them to go to our regular doctor. So my other daughter has gone to find another doctor.

Meanwhile my wife saw me in panic and told me not to worry as she was feeling better and asked me to lay her down. As I was lowering her in the bed she closed her eyes and I felt her breathing heavily. But while she was in my arms I suddenly found that her breathlessness had stopped. Looking at her closed eyes I thought that she had gone to sleep. But she was inert and the expression of pain on her face was replaced by calm. Was she in coma? I did not suspect anything more serious as all her doctors had repeatedly said that there was nothing wrong with her.

As I sat down beside her on the bed, my daughter came rushing inside the room. She was followed by a doctor. But he was breathing fast as he had come almost running inside the building with my daughter. He had come for the first time to attend to Bhagwati. He was not known to us as we had never gone to him for treatment. Yet at that time he looked like God to me. He examined Bhagwati. In my anxiety I had started

asking him about Bhagwati's condition before he had completed examination. I also asked him whether she was in coma. He gave me a patient hearing. But then he told all of us that Bhagwati was no more and he was extremely sorry for that. We were shocked. How could she be dead when there was nothing wrong with her? My world suddenly shattered.

How could she die so soon when she was being treated by eminent doctors ? And they had assured us that she was doing well. The doctor again listened to my outburst silently. I looked at his face and realised that what he was saying was true, the operation and treatment by eminent doctors notwithstanding. I tried to control myself. I remember my next act was to offer the doctor money. For the last so many months I had got so used to offering money for even 'nothing wrong with Bhagwati' kind of consultations with big doctors that this was almost a reflex action. I was also used to doctors accepting the money. But not this one. I was so surprised that for a second I forgot that Bhagwati was dead. How can there be a doctor who refuses to take money? But it was as true as Bhagwati's death. With money in my hand I kept on looking at the doctor. This one had come almost running to attend to a patient who was not known to him. He was feeling sorry that he could not reach a little earlier to save her life. And now after sympathising with us he had proceeded back without accepting any fee from us. A really good human being, or should I say a really good doctor?

As I looked at the serene face of now departed Bhagwati with tearful eyes, I saw faces of Sharad Pandey, Pahlajani and the lady doctor next door who refused to attend to Bhagwati. I felt revolted. Were they responsible for Bhagwati's death ? What helped to control my anger was the behaviour of the last doctor who saw Bhagwati and pronounced her dead.

Bhagwati expired with the same symptoms for which she had been operated. Being lay persons we did not immediately realise the enormity of the negligence and the suppression of facts on the part of the doctors who were very well aware of the true state of her health. We had no knowledge about all this and our suspicions were first aroused when, a month later,



we by chance met one of the assistants of Sharad Pandey attached to Nanavati Hospital. He said he was present in the operation theatre and the doctors had failed to locate the vein for bypass. This was confirmed by another employee, a nurse working in ICCU of the hospital and who had attended her. We happened to meet her coincidentally, sometime later on a bus. This nurse told us that everyone in the ICCU ward knew that the operation was unsuccessful and that the patient would die soon.

At this stage we tried to piece together the real events that took place on the basis of available records and the information given by Pandey's assistant and the ICCU nurse. I will not name the doctor and the nurse as I know fully well that none of them will now be ready to testify. I also do not have any bad feelings on their behaving like this as they also have to protect their jobs in the present medical care market which is tightly controlled by big hospitals and their big doctors.

After I was reasonably satisfied that Bhagwati had died due to medical negligence, I decided to proceed against them. I wrote to the Indian Medical Association and the Medical Council of India as I did not know whom to approach. When I did not get a reply, I called the IMA office and was informed that I should write to the Maharashtra Medical Council (MMC).

On May 3, 1990, I sent a complaint to the MMC. I received no reply, so I sent them a detailed letter again on the May 26 but even then I did not receive any reply. On the May 25, I also wrote a letter to the medical superintendent of Nanavati Hospital asking him to keep all the papers pertaining to the operation in safe custody. On the June 26, I wrote to him again, this time requesting him for xerox copies of all the reports. I personally went to deliver this letter to him. At that time he was not present in his room. His peon asked me to deliver the letter to the clerk in the office. But I insisted that I wanted to see the medical superintendent himself. As we were arguing with each other Dr Shah, the medical superintendent, walked in. As I approached him to deliver the letter, he refused to talk to me. I stood my ground and kept requesting him to take the letter and sign on the

copy. But he just kept going through some papers and did not bother to even look up at me. I then left the letter in his office and left. The medical superintendent informed me by a letter dated June 27 that records would be produced in the court as and when required. On the other hand, I personally approached the MMC many times, but the standard reply was, "It takes time". They also said it was their practice not to reply to letters.

I approached a prominent criminal lawyer for filing a case as the MMC was not giving a reply. The lawyer was nice to me. He listened to my story and promised that he would take my case. Coincidentally, a cardiologist friend of that lawyer was sitting in his office when I went to meet him and was listening to what I said. The cardiologist agreed to go through the medical papers and give his opinion. The lawyer also liked the idea of getting his opinion.

After a few days the advocate told me that he would not take my case as his doctor friend did not want to get involved. I explained to him that I was not interested in getting his cardiologist friend involved in the case. The papers were given to him to get his opinion on the medical facts of the case so that he (the lawyer) could properly prepare the case against the negligent doctors. The answer to this given by the lawyer upset me the most at that time. He told me that both the accused doctors (Pandey and Pahlajani) were known to his cardiologist friend personally and he would not like to take a case against his friend's friends. Ironically, though the lawyer backed out, he charged Rs 500 for the 'trouble' he had taken to go through the papers for me.

Then, I approached another advocate who agreed to take my case. I thank him for it. I filed a complaint through my advocate, against the three doctors (D B Pahlajani, Sharad Pandey and N N Shah, medical superintendent of Nanavati Hospital) in the MMC on August 4. I kept on writing to the MMC, reminding them of the delay, but they did not care to reply.

On October 11, I filed a civil suit in Bombay against the three doctors. My complaint was that these doctors acted in collusion,



deliberately suppressed information regarding the outcome of the operation and the subsequent state of the patient's health. We were at all times told not to worry as everything was all right. Pahlajani at all times advised us that she should get exercise by walking, knowing full well that she had suffered a heart attack. Pandey failed to examine her in spite of making her wait for over eight hours. Further by suppression of facts these doctors prevented us from seeking any further or alternative treatment.

## MMC's Reluctance

My advocate again wrote to the MMC on January 27, 1991 for their inaction, to which we received a bland reply that the complaint was being processed as per the procedure laid down in the rules 62 to 75 of the MMC. I had to go to the MMC and ask for the rules 62 to 75 which pertain to the procedure for proving and disciplining doctor who has committed misconduct. I met the president of the MMC along with my advocate in February 1991 and urged him to conduct the inquiry expeditiously, but he did not do anything in spite of his assurance to do the needful. Again my advocate wrote on March 13, for which no reply was received. It was clear now that the MMC, for some dubious reasons, was dragging its feet. For six months after the complaint was filed the MMC had not even started any proceedings. I was facing a real dilemma.

My lawyer told me that the only thing that could be done in such circumstances was to file a petition against the MMC in the Bombay High Court to get an order directing the MMC to commence hearing in the complaint. I got worried. The MMC is a doctors' court. I had approached it to get justice. If I were to file a case against this court to consider my complaint, I would be antagonising this court. Even if I were to get an order from the high court asking the MMC to hear my complaint, would the judges of the MMC (MMC members, most of them doctors) take it kindly and give me justice? In the meanwhile I had come in contact with P C Singhi whose complaint against a doctor was being heard by the MMC. He was also very critical of the MMC's functioning but he had very carefully avoided making any statement on it in the public. And it is true that normally one

tries to maintain good relations with the agency providing justice so that on technical grounds the case is not put in cold storage or even dismissed. But what was I to do when my case was not coming up for even the first and preliminary hearing? This was the most difficult decision to take. I had realised that I did not have many options. It was perhaps better to fight all the way rather than just wait and wait. Moreover, with the passage of time I was worried about possibility of the doctors and the hospital tampering with Bhagwati's medical record which was still in the possession of the hospital. So I decided to take on the MMC.

On March 22, 1991 I filed a writ petition against the MMC in the high court for their inaction and for immediately summoning all the relevant medical records and documents relating to my wife from the hospital. The petition came up for hearing before admission on April 9, before Justice Bharucha and Justice Sawant. The Registrar of the MMC assured the court that the case would be taken up and expedited by April. On this assurance the petition came to be withdrawn.

Thereafter in an empty and formal compliance with the assurance given to the court and by way of pretence, the MMC addressed a letter dated April 10 calling me for a meeting on April 26. But when I went there to attend the meeting I was casually informed that the meeting had been postponed and no further date had been fixed. I again wrote to the MMC on May 21. Thereafter, I received a letter dated June 7 asking me to come for the inquiry on June 28 before the executive committee of MMC consisting of five doctors.

The inquiry started at about 11 am. I was waiting for my advocate to arrive and so informed the MMC. But to my utter surprise, I was told by the MMC members that advocates were not allowed at that stage of inquiry. I felt as if I was sinking. How could I argue against these doctors? What do I know about medicine and law? If the complainant could not have any assistance of medical or legal expert during the inquiry in the den of doctors, the MMC, how would he or she ever succeed in getting a doctor punished by the doctor members of the MMC ?



While I was worried about the fate of my case I was informed that on that day they had summoned Pahlajani and Sharad Pandey. However, on making inquiries I found that the third respondent, N N Shah, the medical superintendent of the Nanavati Hospital, was neither sent letter/summons nor otherwise asked to appear for the inquiry.

I was told by my advocate that the MMC was some kind of court. I therefore expected the scene of inquiry to resemble that of the court. But to my initial pleasant surprise, I found two tables joined together and laid out for the inquiry. I thought at least here I would not be as afraid as in a court. But in no time after the inquiry started, my happiness gave way to the depressing realisation that the informal non-court atmosphere created at the scene of the inquiry was not for the benefit of the complainant. I found that informality was treated as an excuse for not keeping proper record of the proceedings of the inquiry and it was primarily to help the doctor. I was told that I would not be allowed to cross examine the accused doctors as it was only a 'preliminary' inquiry. Only the five executive committee members of the MMC would ask questions and nobody else. Such a procedure and the seating arrangements (I and the accused doctors on one side of the table facing five MMC doctors) made the inquiry resemble an interview in which I and the accused were queried by the interviewers in order to 'select' a 'truthful' candidate. Thus, in essence, the inquiry replaced search for justice by competition and selection. Needless to add, in the interview for selection, more often than not, it is the candidates who are friendly with the interviewers who succeed.

During the inquiry they first took my statement and cross-examined me for about two hours. Thereafter they asked Pahlajani to speak. He spoke for about 20 minutes. The MMC executive committee members asked him a few questions. Then Pandey spoke for about half an hour. He was also asked only a few questions by them. At this I felt agitated. Pandey had made grossly false allegations and given some outrageous explanations for his otherwise unethical conduct. When I could not control myself I stood up and told the MMC that Pandey was making false statements. In response I was curtly reminded that

in that inquiry only the MMC would ask questions and nobody else.

I submitted a medical opinion which was prepared by an eminent cardiologist after going through Bhagwati's medical papers in my possession, but was not signed as the doctor did not wish to be identified. The MMC president accepted it, but changed his mind when two doctors of the executive committee (EC), and not the accused doctors objected on the ground that it was unsigned. I explained them that no doctor was ready to give an opinion in writing as they considered it to be professional suicide. The young doctors feel they would be blacklisted in future for jobs if they were identified. "You are a fact finding body, in the circumstances, you consider the points mentioned in it. Or send the opinion to some other impartial cardiologist for verification", I pleaded. But they did not accept my contention.

At the MMC, one has to fight with hands tied behind one's back. How can a complainant present or argue a case in the absence of written medical opinion as no doctor is ready to be identified ? They gave no reply. Apart from that, isn't it a cardinal duty of the MMC to form a medical opinion by calling an impartial expert ? Are all specialities of medical science already represented in the EC of the MMC that the EC members do not feel the need to take the opinion of relevant medical specialists? If the opinion of a general practitioner or an unsigned opinion of a cardiologist on the medical facts of a cardiac case is inadmissible in the MMC inquiry or considered inappropriate, how can the opinion of non-cardiologist EC doctors of the MMC be relevant? But the MMC is not bothered by such issues. They refused to take the medical opinion on record as evidence. Perhaps it is more interested in saving its doctor colleagues than in finding truth or dispensing justice.

At this stage another mistake of the MMC was discovered. I was all along under the impression that the MMC had summoned all the doctors against whom I had complained. But during the cross-examination the president of the MMC realised that they had not sent summons to the third respondent, the



medical superintendent of Nanavati Hospital. To cover up the mistake he said to me, "I think your complaint was only against two doctors ie Pandey and Pahlajani". I told him that my complaint was against all the three doctors including Shah. To this, he kept quiet.

Funnily while abrogating all powers to cross-examine the accused, the MMC members did not think it necessary to bring on evidence the medical records of Bhagwati. In medical cases it is common sense to know that the most important documentary evidence available are the medical records. But the MMC appeared to be totally ignorant of that. Would such doctors of the MMC sitting to give judgment on unethical and negligent behaviour of their professional colleague ever give justice to the victim patient or his/her relative ? I felt frustrated and disillusioned. Although I was stripped of all basic and natural right to speak and cross-examine the accused, I still decided to fight on. I thought I owed much more than that to Bhagwati who died due to the dishonesty and negligence of these doctors. So at the end of the hearing on June 28, I pointed out to the MMC that they were conducting the inquiry without providing me with a copy of the medical record. But they seemed to be least bothered about the medical records. So I gave them a letter requesting them to call for the medical records from Nanavati Hospital and making it clear that in the absence of the records it would not be possible for me to fully sustain the case. As it often happens on such occasions the letter had an effect. They asked me to collect the medical records on the next day and fixed the next hearing a day after ie, on June 30,1991.

The MMC charged me Rs 493 for the photocopy of 493 pages of the medical record at the rate of Re 1 per page, while the normal market rate for photocopying in that area is 50 paise per page. Afterwards when I went through the record I found that out of 493 pages about 200 were in duplicate.

On June 30, 1991 I gave the MMC a letter requesting for time as I was given a copy of the hospital medical records only at 3.10 pm the previous day. I asked for two weeks' time to go through medical records, get medical opinion on their content and to

make my presentation to establish a *prima facie* case. I must mention here that the unsigned medical opinion procured by me earlier was based on Bhagwati's medical papers available with me. Now with full hospital record available I wanted a cardiologist to examine them and give a fresh opinion. I also asked the EC members of the MMC in writing to give due consideration to the fact that I was not at all conversant with medical matters and so unless I took the advice of a medical expert it was not possible for me to understand and interpret the medical records. Two weeks time though not sufficient given the non-cooperative attitude of most specialist doctors, at least gave me a reasonable chance to make an effort. I pleaded with them, with my hands folded in front of me, not to proceed with the hearing on that day, ie June 30, 1993. But my pleading was in vain. They knew how to defeat the patients and their relatives. They went ahead with the hearing on that day. It lasted for about two hours.

As both the doctors had made some wrong and misleading statements on June 28 and also, we were not allowed to cross-examine each other, I gave them a letter at the start of the hearing. The EC members of the MMC insisted that I should read out the letter first and then submit it. In the letter I wrote that Pandey had said the operation was of a very serious kind and they needed six bottles of blood for the operation. But Nanavati Hospital took 11 bottles of blood from us, donated by our friends and relatives. We were charged Rs 1,600 for the same. Regarding the seriousness of the operation he had told us that it was a routine operation which he performed four to five times a week. Pandey told the MMC that I neglected my wife and did not take her to him in spite of his being the most available person in the hospital. To this, I wrote that he had admitted earlier that in spite of his promise to see her, he did not do so after making her wait for eight hours. Also, he was not present at his OPD on January 19. How then could he blame me for neglecting my wife ? I said he was the most available person for fresh operations and not for old cases ie he was 'most available' only for his own benefit. Regarding Pahlajani, I wrote that MMC doctors on the panel had not asked him the most vital question regarding his claim that the operation was a very serious one. How then would he suggest that the patient exercise regularly and climb three floors immediately after the operation?



The president said they would certainly ask the question but changed his mind when two members of EC objected to allowing the complainant to ask questions of the accused doctors. They claimed that to do so was against the rules of the MMC Act. Then they went even further, they argued that my suggesting questions to be asked to the accused doctors was contempt of the Council. Who was I to tell them what to ask and what not to? I told them that in my letter I had not mentioned what should not be asked as they were at liberty to ask whatever they liked. But by omitting certain crucial questions absolutely essential to bringing out the truth from the accused doctors they were not doing the right thing. This angered them a lot. They became very offensive and demanded that I should be asked to apologise for submitting such a letter.

In the inquiry room of the MMC there was nobody to defend me or even to provide some moral support. The accused doctors were enjoying my discomfort. I was really scared. So many big doctors were sitting there and telling me that I had absolutely no right in the inquiry and some of the members of the EC were vociferously acting almost like advocates of the accused doctors. I got a feeling that my case was sinking. I realised that the MMC was neither sensitive nor sympathetic to the complainant. It was acting more like a forum to help the accused doctors. In that desperate position in order to salvage my case and in spite of knowing fully well that I had committed no contempt of the Council, I decided to apologise. I apologised and changed the statement to read that Pahlajani had evaded the question about how he advised her to climb three floors knowing that the operation was a very serious one.

After tormenting me in such a way for a long time, the MMC announced adjournment of the inquiry. To my surprise the MMC did not give me a copy of the proceedings for both the days. I enquired about the record of the proceedings and as to why neither accused doctors nor I were asked to sign each page of the record. The members of EC who had been taking objec-

tion to whatever I had tried to say during the inquiry and who were instrumental in making me apologise brushed aside my inquiry about the record of the proceeding by saying that the rule did not permit such a thing and who was I to tell them how to conduct an inquiry. Frustrated and tired after the ordeal of three days I had to leave the MMC office without getting any record on what transpired at the inquiry.

When my advocate came to know about how the inquiry was conducted by the MMC he was very upset. So on July 5, I requested the MMC to allow my advocate to represent and argue my case and also asked for copies of the statements of the proceedings held on June 28 and 30. But there was no reply. On July 27, I submitted my letter based on medical opinion given to me by a prominent cardiovascular surgeon who had also in the end refused to sign it claiming it was 'professional suicide'.

As there was no reply from the MMC till October, I filed a second writ petition against them. When the petition came up for admission before Justice S P Kardukar and Justice S H Kapadia, the MMC representative was absent. The court ordered that summons be issued again to the MMC and also to the government of Maharashtra, the second respondent. When the petition again came up for admission on December 4, the MMC did not attend but the advocate for the Government of Maharashtra did.

The judges felt that the writ petition need not be admitted at that stage and disposed of it by giving directions to the MMC. The MMC was asked to dispose of the case as expeditiously as possible and preferably within six months in accordance with law. In view of the above direction, the writ petition was allowed to be withdrawn. The court's order was served on the MMC on December 6.

The third petition became necessary due to a letter dated December 5,received by us on December 11, from the MMC. The date of the letter was cleverly put. The high court had given direction to MMC on December 4 and the said high court order was served to the MMC on December 6. Apart from the date, the contents of the letter was shocking. I was under the impression



that the inquiry was incomplete and that the new date would be communicated to me. The MMC was yet to record evidence of the third accused Shah. I had given several letters requesting the MMC to complete the inquiry quickly and to allow my lawyer to remain present. I had also given them a letter interpreting the medical records given to me during the last sitting of the inquiry. And above all, I had also filed a writ petition in the high court for the early completion of inquiry. In spite of all these, the letter said that the inquiry had been completed on June 30. Not only that, on that day itself the EC had prepared its 'findings'. To top this, the letter said that the 'findings' of the EC were discussed by the meeting of the MMC on September 20 and all members present had unanimously accepted them. And what were these findings so unanimously accepted by the members of the MMC? That Pahlajani and Pandey were not guilty of any medical negligence or suppression of facts? The letter said that there was no *prima facie* case against the two doctors and asked me to collect the copies of the inquiry of proceedings held on June 28 and 30, 1991.

It took some time and lots of effort on my part to overcome my disappointment and anger against the MMC. On December 19 I collected my copy of the inquiry proceedings for which they charged me Rs 50 for 10 pages. But my cup of sorrows was still not full. When I read the proceedings I was shocked. Pandey's statement taken on June 28, 1991 in which he had admitted that he did not see Bhagwati after making her wait for eight hours was completely missing and only some questions put to him by the EC members were there. Also in my statement they had twisted or added some words in favour of the doctors. For N N Shah's absence during the proceedings, they had blamed me and tried to cover up their mistake. Overall, the recording was wrong and contained statements never made by me.

There was no doubt in my mind that MMC was not interested in respecting due process of law and natural justice. Apart from the way they conducted inquiry and recorded its proceedings, there was other evidence for coming to this conclusion. I had filed a second petition in the high court in October 1991. Two hearings of this petition took place, the last on December 4. It

was a case for speedy conduct of inquiry. Although the MMC claimed later that the EC had passed its judgment on June 30 and the MMC had accepted it on September 20, on both the dates of the high court case MMC did not think it fit to communicate its position to the court and remained absent. Only when the high court gave them a directive to complete the inquiry fast that on the following day they sent me a letter saying the inquiry was not only over but the complaint was also dismissed. This way, in order to save their doctor colleagues the MMC perpetrated fraud not only on me but also on the high court. This shows the extent to which a quasi judicial professional body can go to protect the interests of its members. Clearly this is the reason why a big section of doctors want the Medical Council and not the consumer court to try the cases of medical malpractice.

So in my third petition before the high court I asked for a direction that the MMC should conduct a proper inquiry. Later on at the direction of the court when we took inspection of the MMC documents referred to in their affidavit in reply, they revealed that in the meeting of the Council that took place on June 28, 1991, only five persons were present, and on June 30, 1991 when the order was passed only four persons were present!

In the private hospitals the OPD is conducted by junior doctors only. The senior doctors rarely attend it as they are so busy that they have no time to do so. The name plates showing their times at the OPD only mislead the patients. The only place you can see these seniors is in their private clinics and consulting rooms.

I had noticed that during tea time some of the Council members participating in the enquiry were chatting with one of the accused doctor in the room of the assistant registrar. Can anyone justify such conduct of a person conducting an enquiry of a judicial nature? Going through the records and proceedings before the MMC, I found to my surprise that the doctors had filed a reply/explanation dated March 21 which was never shown to me or given to me at any time before or during the inquiry. I was even never told by anyone nor was told by the Council that such a reply had been filed before the Council.



The Medical Council is a partisan body. The composition of the Council itself is unjustified, as its panel of judges as well as the accused belong to the same profession. In the Council nominated members and government representatives rarely attend meetings, leaving the field clear for doctors who have got elected by using dubious means and huge funds. And even if by chance there is a rift between doctors, and the patient happens to win the case, as Singhi could, they merely issue a warning letter to the doctor. And this they do even in a blatant case of negligence in which the patient had died. What use it is to the patient?

I wrote to the IMA and the MMC, neither replied for months. Finally, I had to move the court to force the MMC to take up my case. I had to go to the court again and again to get them to give their decision. In my opinion, if somebody wants to loose the case, wants to get intimidated and humiliated then only should he or she go to a Medical Council.

Finally I write a para to caution persons who desire to file a complaint against the doctors in the MMC or in the court. It is not an easy job. What happens in the MMC I have already written about. And in the court it takes a number of years for the case to come up. The delay in the court is also very frustrating. In spite of my best efforts to get it expedited, my petition against the MMC filed in December 1991 is still pending. The delay is a deadly poison in our judicial system. The civil suit filed against the three doctors in 1990 will still take five years to come on board. Also it is costly.

Further as time passes you will find the number of your supporters declining. Initially they will support you out of sympathy. But then one after another they will start saying, "What will you get now from the case? The patient is already dead, she will not come back. Also it will be very difficult for you to get doctors convicted. You are unnecessarily wasting time and money." This type of talk will demoralise you. And some may also consider you a crazy person or a trouble maker. Initially many will sympathise with you, but subsequently when you go to meet them in need of time or when you are depressed, as it invariably happens, some of them will listen to you in such a way that you will get the message that he

thinks you are wasting his time. He will not say anything to you, but you will not feel like visiting him again. Only some with a dedicated mind for social causes will remain with you and the rest will go one by one.

The complainant should think twice before filing a complaint. In the prevailing circumstances you will find a lot of difficulties in proving the case. Also you will find hardly any doctor coming to assist you in the case. In spite of the above if you still have a will to file a case, do so. After all somebody, someday has to find a way to break the stone walls.

# *Who Regulates Hospitals?*
## *Who Suffers?*

**Yasmin Tavaria**

Saturday, June 24, 1989, is an unforgettable day in the lives of our family in particular and for many others involved in the issue of medical negligence in general. It was a rainy day and my father as usual left home at 11 am to get his copy of *Blitz* and deposit a cheque in the bank, little knowing that he would never return home. As he was crossing the road to go to the bank on a pedestrian crossing, a speeding motorcyclist knocked him down. My father sustained a head injury and was bleeding profusely and was taken to St George's Hospital nearby. When I got home from work at 1 pm, I inquired with my mother where father had gone and why he had not returned as yet. Mother was already very worried and said he should hopefully return any moment. We waited for him to get back so we could have lunch together but up to 2 pm he did not return.

Worried sick by then and suspecting something untoward had happened, my uncle went to the bank to enquire about Dad only to be told that he had not gone there at all. Apprehending trouble my uncle and my neighbour then went to St George's Hospital to find our if any accident case had been brought in for treatment. Right enough, Dad had been admitted in the casualty ward with his head wound sutured up. On inquiring, the doctor on duty said that it was a minor wound. He was under observation and we could take him home the next day.

Soon after, Dad asked for some water. I gave him some. Immediately on drinking it, he vomited a dark brownish red liquid which looked like blood. I got scared and insisted that the doctor discharge him, so we could shift him to a private hospital for observation and thorough check-up. We took his discharge the same evening against medical advice and we shifted him to the Parsee General Hospital. The next morning, various detailed investigations were done, including a CT scan, which revealed the formation of blood clots in the brain (haematomas).

Due to this brain haemorrhage, he started having breathing problems and had to be put on oxygen. Two days later (June 27) when his breathing became very heavy, he was put on a respirator and shifted to the ICCU. He also became semi conscious and continued to remain so and on the respirator for a week, while he was being treated for the dissolution of the clots. Gradually, his condition started improving and he was taken off the respirator. A repeat CT scan was done which showed that the haematomas had dissolved. A month after he was admitted to the ICCU, ie on July 27 Dad was shifted out to a private room for further recuperative care and treatment.

### Beginning of Problems

Dad had become very weak and was drowsy most of the time. Dr F E Udwadia, his consulting physician, recommended that a complete blood count be done. The blood count showed that dad's haemoglobin count had dropped very low. Hence Udwadia asked the doctor incharge to arrange for a 100 cc packed cell blood transfusion. This transfusion was ordered on the morning of August 2. However, for reasons best known to the hospital staff and despite repeated pleas to hurry up, the transfusion was started only at 5 pm.

Immediately after the transfusion was started, the doctor left the ward, saying his duty time was over. In spite of my request to wait for sometime to ensure that there was no problem, he left. Within 10 minutes of starting the transfusion, Dad started complaining of breathlessness and started shivering. I ran and fetched the doctor on emergency duty. He said this was the normal reaction to blood transfusion and would subside soon. However, when the rigors and breathlessness continued, I again summoned this doctor and insisted that he stop the transfusion, which he did. By then 30 cc of blood had already been given. Emergency treatment was also given. But by then Dad had developed fever, which began rising rapidly. Throughout the night Mum and I sat by his bedside applying eau de cologne and ice packs to his forehead. Some injections were also given to bring down the fever. But nothing helped.



The following morning, August 3, about 8 am, the day nurse brought Dad's medicine reports and charts to the room in preparation for the visit of the honorary doctor. Out of sheer curiosity, to find out Dad's haemoglobin count at the time of admission and to what level it had dropped now, I started going through the papers. In the process, I came upon Dad's blood group. I discovered that while his blood group card showed him to be A +ve, the label on the bottle, which had been discarded the previous day and which was still hanging besides his bed, showed that the blood which was transfused to him was B +ve.

Immediately, I realised the colossal mistake made by the hospital staff and the reason for Dad's discomfort and high fever. I also found among the papers the blood cross-matching report which showed that the donor and recipient (ie my Dad) had the same blood group, ie B +ve, and that the two samples of the blood were found to be matching. I immediately took out the original blood group card and the cross-matching report from the file and took them to the doctor in charge of the ward. He was the same doctor who had given the transfusion and walked away the previous evening. He was surprised to note this discrepancy and admitted the mistake that a wrong blood group had been transfused. He, however, blamed it all on the lab technician and attributed it to carelessness on her part.

When the honorary doctor Udwadia came for his rounds sometime later, I informed him of this. He was very angry with the hospital staff and ordered an inquiry into the matter. Understanding the gravity of the situation, I immediately made a written complaint to the administrator of the hospital, demanding an explanation for this serious lapse and asking for stern action to be taken against the erring staff. A meeting was called by the chief administrator. The chief honorary pathologist, the RMO, the honorary medical superintendent, a committee member and the lab technician who had cross-matched Dad's blood sample with the donor's and reported them to be compatible attended it. They all admitted that a serious mistake had occurred and the technician was verbally admonished for her negligence.

When I asked the pathologist about the likely reaction of the wrong transfusion, I was told that there could be a further drop in Dad's haemoglobin level or he could develop jaundice or could suffer a renal failure. I was asked to keep a close watch on his urine output.

The same day, ie, August 3, around 4 pm I noticed that though Dad's intake of liquid till then had been 1,500 ml, he had passed only 350 ml of urine. I immediately informed Udwadia's houseman and requested him to contact Udwadia. But unfortunately, Udwadia was not available till almost 8 pm Around 8.30 pm, when I had gone down to get some food, the houseman came to the room with a surgical trolley and asked my mother to leave the room. When she inquired what they were doing he was evasive. Scared, she told them to wait till I returned in a few minutes, but was rudely told that there was not time to waste and that he was acting on Udwadia's instructions.

Just then I reached the room and they told me that they wanted to do a central venous puncture (CVP) to measure the blood pressure. This procedure took 40 to 45 minutes. No sooner was it over and we were allowed inside the room, I noticed that Dad was very uneasy and gasping for breath. I prevailed upon the doctors to shift him back to ICCU where he would get better attention and care. This they did. Again an endotracheal tube was inserted in his mouth and oxygen pumped into his lungs. Meanwhile, I phoned Udwadia at his residence to request him to come and see Dad. He said to tell the registrar to contact him.

Soon after, a nephrologist, Dr Bhupendra Gandhi, from Breach Candy hospital was summoned to perform peritoneal dialysis to drain out the excess fluid which had accumulated in his body. This fluid was applying pressure on his heart and thereby had led to the failure of the left ventricle, which in turn, had caused the blood pressure to fall. The dialysis did not work and had to be abandoned after one cycle. By this time it was midnight. Gandhi then left instructing the ICCU registrar to administer diuretic injection, ie Lasix, to drain out the excess fluid from the body. After Lasix was administered, Dad started



passing urine and the functioning of his kidneys improved to some extent.

A couple of hours later, ie on August 4 morning, Gandhi, Udwadia and the honorary pathologist examined Dad and assured us that Dad's condition had improved. Throughout that day he was given heavy dosages of Lasix and other drugs. Around 8 pm, after a telephonic conversation between Udwadia and the ICCU registrar, the endotracheal tube which had been inserted the previous night in Dad's mouth was removed and I was told that his condition was stable. Feeling relieved at this, I had dinner and went to sleep on the sofa outside the ICCU.

Around 4 am on August 5, I was awakened by the ward boy and asked to go to the ICCU as the doctor wanted to see me. Suspecting that something was seriously wrong, I rushed inside only to find Dad gasping for breath. His life seemed to be fast ebbing out. The nurses and the doctor were trying desperately to revive him but failed. Sadly, at 5.55 am he breathed his last.

### Cover-Up Operation

Since Dad had met with an accident, this was a medicolegal case and had to be reported to the coroner's court and the facts leading to his death. No sooner did the news of Dad's death became known, the hospital officials, like the honorary medical superintendent and the RMO, descended on the ICCU to doctor the report and ensure their safety.

The first version was prepared and given to us by 9.30 am This version did not mention anything about the left ventricular failure due to the kidney failure, both resulting from the mismatched blood transfusion. It gave the cause of death as "an old case of myocardial infarction and general debility due to prolonged illness and hospitalisation leading to cardiorespiratory arrest". This was obviously unacceptable to us and we insisted that the authorities not waste any more time and give us a true report of the facts.

After many heated exchanges and intervention of Udwadia, a somewhat factual report was prepared and given to us. However, in this too, the cause of death was put merely as "cardio respiratory arrest". According to a medicolegal opinion, the correct way to state the cause of death is to first write the original cause which led to the cardiorespiratory arrest because cardiorespiratory arrest is always caused by some factor or the other. So the circumstances leading to cardiorespiratory arrest should be mentioned.

Armed with this certificate, I went to the police station under whose jurisdiction the accident had occurred. Along with a constable and their report, I went to the coroner's court to get the disposal certificate which enables us to claim the body and perform the last rites. This was given to us without any delay. At 2 pm, we took possession of Dad's body from the hospital – eight hours after he had breathed his last – thanks to the harassment and falsification of documents by the hospital.

Thus, on August 5, 1989, a resolve was born in me to fight against the demigods of the 'noble' profession – medicine – and their highhanded and autocratic way of dealing with seriously ill patients, who were the mute recipients of negligent treatment, often by unqualified doctors employed on low salaries by hospitals, which are out to fill their coffers regardless of the risk of life and limbs to unsuspecting patients who come to these institutions in the hope of getting cured of their ailments.

The day after Dad's death ie on August 7, I approached the Gamdevi police station and asked the sub-inspector on duty to register my complaint against the doctors of Parsee General Hospital (PGH). After listening to the whole sordid story, he said since the doctor had written in the report to the coroner that Dad had died of heart failure and since nothing was mentioned clearly that he had died as a result of negligence, he could not register my complaint.

After a heated argument during which I forcefully put my point across that no criminal would openly admit to a crime, he finally told me to give him a written complaint. Fearing further resistance to registering my complaint, the next day I requested a senior police inspector known to me to accompany me to hand over the complaint. It was accepted by the officer on duty.



I also made a written complaint to the administrator of the PGH and the managing trustees asking them to let me know what action had been taken by them against the negligent staff. They did not reply. So I followed this up with a reminder giving them a time limit for a reply, failing which further action as deemed fit would be taken by me against the hospital authorities. During this period, I made it a point to meet the honoraries who had treated my father. While all of them were very sympathetic and admitted the negligence leading to his death in the privacy of their consulting rooms, at a later stage, when it became a legal and public issue, all of them gave varied and biased statements.

Meanwhile, with a view to mount pressure on the hospital authorities and the police to take action, I approached some newspapers which lapped up the story. Right enough, this put some pressure on the hospital authorities who suspended the lab technician and issued a chargesheet to her and subsequently commenced an internal inquiry. Dr A R Gharatkar, who had administered mismatched blood and was suspended for two weeks, was taken back on the job till the expiry of his contract of one year with the hospital.

During this time, I also filed a complaint with the Maharashtra Medical Council against Gharatkar and followed up with regular personal visits to the MMC office to have my complaint looked into expeditiously. During the course of their investigations, it came to be known that Gharatkar was not registered with the MMC and hence they were unable to take action against him. This revelation itself took six months from the date of the complaint.

The MMC informed me by its letter dated February 15, 1990, that Gharatkar was a homeopath registered with the Maharashtra Council of Homeopathy (registration no 16225) and holding the qualification of GCEH from the Karnataka court of examiners.

Bangalore (1987 batch). I was astonished as to how a person who was neither qualified to give allopathic treatment nor registered with the MMC was in the first place employed by this hospital to dispense allopathic medicine and treatment.

Concurrently, I was doggedly pursuing the complaint filed with the police. I am sure that due to pressure put on the police by a retired deputy commissioner of police who had been hired by the PGH as an honorary security adviser, the Gamdevi police invariably fobbed me off with their stock reply that investigations were still going on and only after the recording of statements was over would they decide upon a course of action.

Upset by this dragging of feet, I approached the secretary, department of home, who, in turn, rang up the inspector at Gamdevi and asked for a detailed report on the case within a month. This galvanised the police into action and soon a FIR was filed by the sub-inspector investigating the case. He found Gharatkar, the staff nurse in charge of the ward and the lab technician guilty of negligence leading to the death of my father.

The three accused were charged through CR no 376/90 dated May 11, 1990, filed by Yashwant Dhoble, the SI of Gamdevi police station, under sections 338 and 109 of the Indian Penal Code which read as follows: "Causing grievous hurt by act endangering life or personal safety of others – whoever causes grievous hurt to any person by doing any act rashly or negligently as to endanger human life or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to two years or with a fine which may extend to Rs 1,000 or both."

After the filing the FIR, arrest warrants were issued for all the three accused and they were arrested in May 1990 and released on a personal bail of Rs 950 each. Subsequently, a criminal suit was filed by the police and state government against the three accused (case no 3113/P of 90) on July 3, 1990. The hearing in this case is yet to begin in the Girgaum police court.

Meanwhile, during November/December 1989, I also filed a civil suit jointly with my mother in the Bombay High Court



suing the hospital authorities for damages since this was the only way in which the management could be made to realise their fault and the disastrous consequences on an innocent patient, so that at least in the future they imposed stringent measures to ensure efficient working of the staff.

In February 1990, when I came to know that Gharatkar was a homeopath, I filed a complaint with the Maharashtra Council of Homeopathy asking them to initiate immediate action against Gharatkar for negligence and also for practising allopathy when the Bombay Homeopathic Practitioners Act, 1959, clearly forbade homeopaths from practising allopathic system of medicine. On August 3, after regular follow-up by with the registrar of the Homeopathic Council, I received a letter saying that a detailed report from the police commissioner had been called for and on hearing from him, further action would be initiated.

After this, the Council refused to move in the matter though the police had charged the doctor of negligence causing death. However, after a written reminder from my advocate on September 27, 1991, demanding that the Council look into the matter immediately as per the authority vested in it and inform us of the date of inquiry (as we had waited for over a year), we received a written reply from the administrator on October 8, which stated: "We have to state that for the above offense, the Inspector of Police has filed a case vide no 3113/P/90 in the Girgaum police court. After the result of the court case this council will take action as per the direction of the court. This may please be noted".

Appalled by this irresponsible attitude, I then approached the secretary of the medical education and drugs department on December 3. The secretary, J Shankaran, heard me patiently and promised to do the needful. The section officer concerned, at her behest, started following up the case. An explanation was called for from the administrator of the Homeopathic Council as to why no action had been taken against the negligent doctor, so far. The next day the administrator turned up at Mantralaya with his files and convinced the section officer that since the police were now handling the case, it would not be correct on the part

of the Council to take any punitive action against the doctor which may turn out to be contradictory to the court verdict. No amount of reasoning by me had any effect on the section officer, who kept repeating the administrator's argument, thoroughly convinced by it.

Then one day, taking time off from work, I went to meet her, armed with a copy of the Bombay Homeopathic Act. I showed her the relevant sections and made her understand that the Council was an autonomous quasijudicial body empowered to take action against doctors registered with it and found to be guilty of acts considered as misconduct by the Council. Unfortunately, before I met her, she had already put her 'misguided' comments on my file and forwarded it to the deputy secretary seeking further directions in the matter. She was honest enough to admit this, but promised to withdraw the file from the deputy secretary and put the correct facts to him. However, to this date nothing has been given to me in writing as to the action recommended or taken by them.

## Who Regulates Hospitals?

During my fact-finding for this case, when it came to light that the PGH had employed a non-allopath to administer allopathic medicine, the fundamental question that arose was: who was the hospital answerable to and which was the governing authority for private hospitals to monitor their working and lay down basic norms. I approached various governing bodies in this regard, like the director of health services who evinced keen interest in the case but expressed inability to do anything in the matter since the PGH was a private hospital, so not under the authority of Director General of Health Services (DGHS), which controlled only the public hospitals.

Finding this door closed, I approached the public health department of the state government and there, too, drew a blank. I was told that there was no monitoring authority for private hospitals to take disciplinary action for the serious breach of employing unqualified medical staff. I was also informed at this stage by the medical education and drugs department that there



were two volumes of hospital administration manuals framed as guidelines for the working of public hospitals. One important information I learnt was that all hospitals within the Bombay Municipal Corporation (BMC) limits were required to register themselves with the BMC.

On hearing this, I went to meet the executive health officer of the BMC. She flatly said that the BMC was responsible for the working of the municipal hospitals only and beyond the mechanical formality of registration of private hospitals, the public health department of the BMC was in no way responsible for their working. However, on persistent questioning that since the BMC was the registering authority, there should definitely be some conditions for registration, I was told that it was a mere formality – the hospital filled the required form and paid the requisite fees and it was then issued a registration certificate.

It was an old clerk who had been with the BMC for a long time who, after hearing my struggle for justice, expressed his desire to help me and showed me an old brown copy of the Bombay Nursing Home Registration Act, 1949, which gave the various details of statutory requirements of private hospitals and nursing homes and the basis for their registration.

Armed with a xerox copy of this, again my rounds to various authorities started and after much discussion with the authorities in Mantralaya and the BMC as well as some medical/health activists, I decided to file a writ petition in the Bombay High Court. This was a public interest litigation (PIL) which raised the issue of accountability of private hospitals and the standards of treatment, equipment, beds and staff.

The BMC had also claimed that beyond the mechanical formality of registration, it had no regulatory powers. I, however, discovered that the BMC had sufficient regulatory powers as well as the mechanism to ensure compliance of minimum standards by the private hospitals. But for reasons best known to them the BMC authorities had not exercised them. It was, therefore, in the interests of patients and the public at large that

there be certain minimum standards provided to private hospitals just as there are minimum standards required to be maintained by private educational institutions, hotels, etc.

It was under these circumstances that a PIL was filed in July 1990. It came up for admission in the court of Justice M L Pendse on August 7, 1990. The judge rejected it on the ground that since I had already filed a suit for damages against the PGH, PIL was to boost the claim for damages. He even declined to entertain the petition for issuing general guidelines to all private hospitals in Bombay.

Being aggrieved by the order, I filed an appeal in January 1991. It came up for hearing in the court of the Chief Justice P D Desai and Justice D R Dhanurea on February 1, 1991, when notice was issued to the respondents, returnable on February ie, 1991. The municipal commissioner and executive health officer were asked to file before the next date of hearing an affidavit with regard to the enforcement and implementation of the provisions of the Bombay Nursing Homes Registration Act (BNHRA) in the areas falling within the jurisdiction of the BMC and the machinery and the modalities which have been devised for compliance.

The BMC duly filed the affidavit on February 18, 1991, and stated that the respondent no 4, ie the PGH was registered under the act till 1987 after which it had not renewed its registration. On July 27, 1990, the PGH had tendered its application in the prescribed form for registration for the years 1987-88, 1988-89, 1989-90 and 1990-91. The BMC further affirmed that it was not aware of the employment of Gharatkar as his name was not mentioned in the list of doctors submitted by the hospital.

At the next hearing on February 25, the judges observed that the affidavit filed by the BMC did not fully and adequately comply with the directions issued in the interim order passed on February 1. Considering the shabby manner in which the order had been complied with, it now seemed proper to direct the municipal commissioner to file detailed affidavit on compliance



of the aforesaid order on or before May 6, 1991. The BMC stated in its affidavit that on receipt of applications for registration by the respective wards, the sanitary inspector scrutinised the documents. She then visited the hospital premises for a spot check. She then submitted a scrutiny report along with her remarks to the ward medical officer (health) who again verified the information given in the application. If satisfied, she passed an order for registration of the nursing home or hospital and after a payment of fees, the registration certificate was issued.

The next hearing of the petition was held on March 11. Consequent to the averments by the municipal commissioner in the affidavit, the judges directed the BMC to place the following information on record through an affidavit by April 16 after proper verification.

1) Whether during the last five years, the medical officers had visited any of the nursing homes/hospitals (NHs/Hs) to whom registration granted for the first time, to verify whether all the statutory requirements were fulfilled. If so, to give particulars and state the instructions, if any, issued or the observations, if any, made on such occasions and the followup action taken thereon.

2) Whether any periodical visits, other than those, if any, paid at the time of initial or renewal or registration, were paid by the sanitary inspectors and/or medical officers to NHs/Hs within their wards during the last five years. If so, to furnish particulars and state the report, if any, made and follow-up action, if any, taken.

3) Whether any NH/H has been refused initial registration or renewal of registration during the last five years on the ground of it having not satisfied the statutory conditions prescribed in clause 5(1) of the BNHRA. If so, to give particulars.

4) Whether any cancellation of registration of any NH/H has been made during the last five years under section 7 of the BNHRA.

5) Whether any penalty has been levied or prosecution launched against any NH/Hospital for contravention of the provisions of the BNHRA during the last five years.

6) Whether the BMC would consider the setting up of a committee consisting of the elected representatives of the people from different wards and other prominent citizens / medical personnel / social workers to supervise the functioning of the machinery concerned with the registration and/or renewal of registration and functioning of the NH/H in accordance with law and, if so, to formulate a precise proposal in that regard and place it for the consideration of the court.

## Historic Order

An affidavit giving exhaustive details of all the NHs/Hs visited and action taken was filed by the BMC. It came up for hearing on April 26, before the Chief Justice P D Desai and Justice P S Patankar who passed the following orders:

> The writ petition has served the purpose of activising the authorities concerned who seem to have woken up and taken certain steps in the direction of the implementation of the various provisions of the law.
> It is expedient and in the interest of justice to direct that a progress report about further action taken in the next two months for the implementation of various provisions of law be submitted to the court. The court directs that all the registered NHs/Hs be visited during this period and that the progress report should contain the findings in respect of the breaches, if any, of the provisions of law on their part and the action taken or proposed to be taken against those of the NHs/Hs which are found to have violated the provisions of law.

The matter was adjourned to June 24. The affidavit was filed on July 11, giving the municipal wardwise details of NHs/Hs found guilty in respect of breaches of provisions of law and action taken or proposed to be taken against them by the BMC. Meanwhile, an interim order was also passed on July 16, stating that

> ... the appellants would be at liberty to seek and be given inspection of the inspection reports mentioned in the affidavit dated July 12, 1991, of the BMC and after inspection the appellants would be at liberty to file a further affidavit.



The respondent, the BMC, should consider setting up division wise committees to supervise the implementation of the act instead of a single committee. An affidavit was filed by us on July 16, 1991, as an affidavit in rejoinder giving details of the lacunae in the public health care, its administration and the steps which could be initiated for proper control of the working of these health centres.

After this, a final hearing of the petition took place on December 4, 1991, wherein the following order was passed.

> The case has been heard at length at the admission stage and interim directions have been issued from time to time. The court noticed that the implementation of the BNHR Act in Greater Bombay has not been satisfactory. Since the proper implementation of the Act is a matter of vital concern, as far as the inhabitants of this premiere city are concerned, it is just and expedient to direct the respondents, the BMC, to set up a permanent machinery with a view to overseeing and supervising the due implementation of its various provisions. Under the circumstances, the court issues the following directions.
> (1) The Municipal Commissioner is directed to constitute an apex committee and three zonal committees with the power to oversee and supervise the implementation of the Act and to make appropriate suggestions and recommendations in that regard to the competent authority.
> (2) (A) Constitution of the apex committee to be appointed by the Municipal Commissioner shall be as under:
> 1) Deputy Municipal Commissioner (Health) as the Chairperson.
> 2) Executive health officer of the BMC as the member secretary.
> 3) A Deputy Director of Health Services, Government of Maharashtra, to be nominated by the state government.
> 4) An eminent honorary doctor attached to any municipal or government hospital in Bombay who is not concerned with the management of any hospital or nursing home.
> 5) The President of the Maharashtra Medical Council or any member of the said Council as may be nominated in that regard by the Council, preferably from Bombay.
> 6) A fulltime professor or reader teaching in any hospital in Bombay and who is not concerned with the management of any hospital or nursing home.
> 7) A prominent social worker, working in the field of public health in Bombay.
> 8) An assistant health officer of the BMC.
> (B) Constitution of the three committees for the city, western suburbs and eastern suburbs, respectively, shall be as under:.
> 1) A full-time professor or reader in any public hospital in Bombay who is not concerned with the management of any hospital or nursing home in

the city to be the chairperson.
2) An assistant health officer of the BMC as the member secretary.
3) A medical practitioner to be nominated by the Medico Friends Circle (Bombay Group).
4) A prominent social worker in the city of Bombay.
(C) The initial constitution of the above committees would be for a term of two years.

The court also nominated the members for each committee for the first two years and recorded the names in the order. The liberty to apply was also given in this order so that, at a future date, if we were not satisfied with the working of the committees we could again approach the court. One has to wait and watch how effective the working of the committees will be towards tightening of controls to improve the standards of health care in our city.

It may be asked that though more than three years have elapsed since my father's death little has been done to bring to book the erring hospital for being negligent and employing an unqualified doctor. But it should be remembered that medical negligence cases have still not come of age in our country and an unbelievable amount of spade work has to be done first to find out the legal implications and the acts and rules as well as the bye-laws governing the medical practice in our land. Some of the acts were framed as early as 1949 and no copies were available at the government press. It was extremely difficult even to locate old copies from clerical staff and persuade them to allow me to take xerox copies of these.

I must also add that though I appointed a lawyer as a retainer as early as November 1989, all the follow-up with various government bodies, the Medical Council and the police was done exclusively by me. I am sure that without the daily follow-ups, literally pestering various people for information, nothing would have moved even to this extent. After my fact-finding missions during the day, I would go to my lawyer in the evening to discuss the facts discovered and their legal implications. We would also discuss further plan of action and our chances of success.

Lawyers have hundreds of cases and unless one is constantly after them they will conveniently forget the case. Left to the



lawyer alone nothing or a maximum to 5 to 10 per cent followup would have been done, in spite of paying heavy retainer's fee at the time of entrusting the matter to him. This is not totally due to lack of interest but because their priorities are different from ours – unlike them, we are the direct sufferers of negligence and hence are more determined in our efforts to get justice for ourselves and punishment for the wrong doers.

# *Comatose Medicine*

## Saroj Iyer

Habib Terrace stands bang on the main road of Lal Baug in the heart of the city. An old stone and concrete building, it has a typical working class ambience. Parab's house on the first floor faces the main road, the noise and the busy life outside in total contrast to the cold reality inside where life has come to a standstill for a young woman since 1988.

As I enter the small room, the sight of 30-year-old Deepa lying almost lifeless on a bed wrenches my heart. Sitting on the couch nearby is her father, watching television with a distant look in his eyes. Her mother is in the kitchen cooking the afternoon meal, with a toddler tugging at her saree. There is a lump in my throat and I'm unable to speak. How do I ask an aging father about his daughter's tragedy, which has reduced her to a vegetable? Seeing the motionless body, it is impossible to believe that a young woman could be so reduced to such a pathetic state due to the callousness of doctors. The lump in my throat grows as the hapless father looks at me with desperate hope. I sit mutely staring at the floor unable to face him or look at Deepa.

Deepa lies almost lifeless on the bed. She has been lying that way for the last three years. Except for her feeble breathing, there is no sign of life. There is a plastic tube with a stopper at its end inserted through her nose into her stomach. She is fed liquid through it at regular intervals. Besides feeding everyday, Deepa has to be sponged, cleaned a few times a day, turned from side to side so she does not develop bed sores and given massage with oil to keep her muscles supple. Her daily dose of medicines costs a small fortune. Apart from money, a heavy investment of time and energy is needed, which her aging parents are running out of.

Parab painfully recounts the entire events, beginning from Deepa's marriage to her three conceptions and unfortunate abortions, her fourth pregnancy and the complications she developed which culminated in this tragedy. The hopelessness he feels is mingled



with flashes of anger and a strong urge to fight those who brought this cruel fate on his daughter, wrecking her life. Deepa is alive, yet dead for the last three years and perhaps will remain so till 'full' death. She has never seen her child nor will her little son know the love of his mother, grieves Parab.

An economically self-sufficient Parab, who had a shop in the busy Lal Baug market, is steeped in debt and reduced to near penury. The medical expenses have crossed Rs 2 lakh, he says and to meet it he has had to sell off his shop and borrow a total of Rs 80,000 from friends and relatives, which he is having difficulty repaying. "This is my fate because I trusted the doctors blindly", he says bitterly.

It is obvious from his narration that Parab had complete faith in the doctors and for a long time never once suspected that they could have done anything wrong. He merely cursed his fate and that of his daughter's in the beginning. His blind trust was shattered only when he was rudely shaken by the reality of the doctor's negligence. Today, he is a cynical man and is also angry at the fact that doctors are ready to dish out their views on what could have gone wrong with Deepa for a price but unwilling to put their signature to them simply because they do not want to antagonise their fellow professionals. What kind of ethics is this, he asks bemused.

After groping in the dark for close to two years about taking action against the doctors, Parab finally filed a complaint with the Consumer Forum. From a defeatist attitude, he has gradually but definitely moved to embark on a determined fight to get justice for his daughter. He is no longer a spent force but a determined man.

### Deepa's Tragedy

The story of Deepa's tragedy in the hands of doctors was narrated by him as follows:

My daughter Deepalakshmi was married to Ashok Jagannath Rane in March 1985. After marriage her name was changed to

Ashwini. Deepa was a pleasant, likable and friendly person, who would easily leave an impression on anyone. Soon after marriage, Deepa became pregnant but unfortunately had an abortion. Thereafter, she conceived twice, but both times suffered an abortion. During this period, ie, between 1985 and 1989, when she had three spontaneous abortions, we consulted many noted gynaecologists, but not to much avail.

In mid-1989, when she became pregnant for the fourth time, our family doctor, S G Parab, advised us to consult Dr Kalpana Desai, who, he said, was known for handling complicated cases. Accordingly, we fixed an appointment to see Desai and saw her at her private clinic at Matunga. After we told her Deepa's history detail, she agreed to take on the case and began treatment.

In the sixth month of her pregnancy, ie in January 1990, Deepa began bleeding. To stop the bleeding, Desai stitched up the mouth of the uterus the following month, ie in February. She then did a scan and gave the date of delivery as May 12, 1990, and added that she would remove the stitches on May 2. However, on April 11, the movement of the foetus stopped. Our neighbour was a retired matron of Bhabha Municipal Hospital. So we requested her to come and check Deepa. She did so and advised that we take her to the doctor immediately and have the stitches removed. She also spoke to Desai on the phone and apprised her of Deepa's condition and told her that the stitches should be removed immediately. Desai, however, brushed her off saying Deepa could see her at her clinic the following day.

The following morning (ie, April 12) at nine, we reached Matunga Clinic and gave a full account of Deepa's condition to Desai. To our surprise, she refused to remove the stitches saying she would do so only on May 2. We felt helpless, not knowing what to do.

Luck was against us. Deepa began having several problems again. Trouble started barely 10 days later when on April 21 she started having pain. The movement of the foetus also stopped. It was 11 in the night and we didn't know what to do. Unfortunately, the following day was Sunday, so we could not consult Desai. Deepa passed the day restlessly and in great pain.



On Monday, ie, April 23, at 8.30 am I phoned Desai and said we were bringing Deepa to her clinic. On reaching, she examined Deepa and announced that an emergency caesarean would have to be done. She called a nurse and asked her to make preparations and took Deepa in immediately.

An hour later, she came out of the operation theatre and said Deepa had given birth to a boy and that both mother and child were fine. But Deepa was not brought out of the theatre even after an hour. Anxious about her condition, we enquired again how she was as also the child. But to our dismay, no one would say anything.

Even as we were making frantic enquiries, the owner of the nursing home who also was a doctor and her two sons, also doctors, accompanied by a fourth doctor, rushed into the operation theatre. Seeing so many doctors rushing in, we panicked and attempted to go in to see what had happened. We suspected that something had gone wrong as Deepa still hadn't been brought out. It was almost two hours now. But the nurses would not allow us to go in nor would they say anything.

Finally, in desperation, I threatened a nurse that I would implicate her too in my complaint if she did not immediately tell us what had happened. It was then that she revealed that as a result of the doctor's mistake, Deepa's pulse had stopped. Her blood pressure had fallen and the doctors were now trying desperately to shift her to another hospital.

A little past noon, Desai came out and said Deepa had panicked and consequently become unconscious. They were now trying to shift her to a good hospital. She assured us that Deepa would regain consciousness within a few hours and there was nothing to worry about. She asked us if we would like her to be shifted to any particular hospital. As we did not know of any, we left the choice to her. Since she had said it was a matter of few hours, we thought we could always decide later.

Deepa was shifted to Matalakshmi Nursing Home at Sion where an ECG was taken out and Dr Ravi Shankar Shetty, a

cardiologist, began treatment. Deepa continued to remain unconscious though her condition showed a marginal improvement a few days later. For 18 days, she remained in coma after which the doctors discharged her only to shift her to a public hospital, Tarachand Bappa Nursing Home behind Sion Hospital. Deepa remained there for another 10 days.

We do not know what treatment was given at these hospitals as they did not reveal anything to us. Whenever we questioned about Deepa's condition, they just said she was improving even though there were no such signs. On the 11th day, Desai consulted Dr Ramani, of Sion Hospital. Though we don't know what transpired between them, preparations were being made to shift Deepa to Sion Hospital, where she was finally admitted.

After a few days at Sion Hospital, Agarwal said Deepa did not need any medical care but merely efficient nursing and would improve faster at home. So, he advised, it would be better if we took her home and nursed her back to 'normalcy'. According to his advice, we brought Deepa home on May 29. Deepa continued to be in coma.

While at Matalakshmi and Sion Hospitals, scanning of her brain was done at Hinduja and another private clinic at Walkeshwar and at Nair Hospital, respectively. Desai kept all these reports with her and didn't let us see any. We repeatedly asked for them till the last day of her last discharge, but she just refused to give them to us. She also did not give us any of the case papers or record sheets.

From the day she was brought home in May 1990, till July, we gave Deepa medicines prescribed by Ramani. In August 1990, we consulted neurosurgeons at the J J Hospital, Dr Yogesh Parekh and Dr B S Paudval, both of whom advised to continue Ramani's treatment. Both of them said that oxygen supply had been cut off for about three to five minutes, causing damage to the brain. We don't know anything about medicine, so we don't understand exactly what 'blocked' means or how it happens: what we do know is that our daughter's brain has been damaged because of the doctors' negligence, reducing her to a vegetable



in which state she has been for the last three years. We don't know whose fault it is. Only those present at the time of the (caesarean) operation can say that.

Though several doctors who examined her, like a homeopath, Dr Faroukh Master of Bombay Hospital and KEM hospital's Dr Chiklikar and Jaslok Hospital's Dr Vaidya, a neurosurgeon, categorically said that her brain had been damaged because oxygen supply has been cut off during the caesarean, however, none would give it in writing.

In the last three years, my wife and I have suffered untold hardships and agony in taking care of Deepa. Our daughter is bedridden, so everything has to be done for her, right from sponging, cleaning, changing, feeding to turning her from time to time so she doesn't develop bed sores. How long will she live like this? We can't bear to see her in this state. We also don't know how long we can look after her as both of us are getting old. Both of us have already undergone operations in the intermittent period, my wife in February 1990 and I in December 1989. So physically, it is getting increasingly difficult for us to take care of her. We have also incurred an expense of over Rs 2 lakh in providing medical and day-to-day care and are over burdened by debt. Every month, we have to spend Rs 7,000 to Rs 8,000 on medicine, massage and other things. Where do we bring that sort of money from?

We also have to take care of her son, who is now three years old. Her husband visits her now and then. We are worried what will happen if he seeks to remarry.

I wrote to the MMC three times, but they did not bother to reply even once. I wrote to all the top police officials, chief ministers, ministers and leaders of political parties and sent reminders two to three times. None has replied.

Will we get justice in this country? Or will we continue to pay for the doctor's mistake? We have filed a complaint with the state Consumer Grievance Redressal Commission and are still waiting for the hearing in the case to begin.

# III
# Medical Ethics and Negligence

# Medical Ethics and Patients

S S Tinaikar

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

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

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

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

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



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

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

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

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

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



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

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

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

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

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

# Medical Ethics as Doctors' Legal Obligation

**Amar Jesani**

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

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

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

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

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

## Medical Councils

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



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

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

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

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

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

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

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

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



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

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

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

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

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

## Code of Ethics

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

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

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



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

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

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

# Role of Medical Councils
## Protecting Doctors?

Colin Gonsalves

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

### Secrecy

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



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

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

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

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

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

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

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



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

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

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

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

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

## Right to Medical Records

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

# Rot in Medical Council

## Case of Maharashtra

**Sunil Pandya**

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

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

# Patient's Right to Know

**M S Venkataraman**

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

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

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

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

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

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

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



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

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

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

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

# Consumer Protection Act and Medical Profession

**Arun Bal**

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

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

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

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

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

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

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

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

6 The right to consumer education.

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

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

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

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

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



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

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

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

## Is the Patient a Consumer?

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

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

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

## Definition of Medical Negligence

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

One final word. These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard



to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.

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

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

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

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

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

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

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

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

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



## Avenues for Redress

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

## Patients' Rights and COPRA

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

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

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



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

## Amendments Required

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

# Negligence in Medical Care and Law

**Mihir Desai**

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

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

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

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

Medical negligence litigation is a response to the following types of questions. What are the rights of patients *vis a vis* doctors and hospital? What if the doctor wrongly diagnoses a disease? What is the level of competence expected of a doctor? Does a doctor have to take the consent of the patient before an operation? If many doctors have handled a patient which of them is ultimately liable? The common issue in all this is the patient's allegation that the doctor has been negligent.

## Negligence and Torts

Medical negligence is a branch of the law of negligence which in turn is a branch of the law of torts. The Tort Law is not based on any act of parliament. It is mainly a judge made law developing over the years through changing judicial decisions. It is not possible to define Torts. Broadly speaking tort is a wrong done by one person to another for which the law provides a remedy. The idea is to monetarily compensate the victim rather than punish the offender, as would be the case in criminal law. It includes disparate events such as car accident, injuries due to emission of poisonous gas, doctor's negligence causing death of a patient, defamation of a person, compensation for injuries suffered by a wife at the hands of her husband, etc. The motives of the offender are not very relevant. The focus is on the victim.

A person is said to be negligent when s/he acts without due care in regard to the harmful consequences of his/her action. When we say that a person has been negligent we are saying that s/he acted in a way that s/he ought not to have acted. This assumes that we know how s/he ought to have acted. The way in which we consider that s/he ought to have acted is the norm or standard which entitles us to condemn the person for being negligent when s/he fails to comply with the standard.

The tort of negligence is made up of the following components:



(1) A duty or obligation recognised by the law requiring the person to comply with certain standards of conduct for the protection of others against unreasonable risks. Initially charitable hospitals used to claim that they could not be held negligent as they had no duty to take care of patients since they were not charging them. Now of course the courts always disregard such defence.

(2) A failure on the part of the person to conform to the standard required, what is known as a 'breach of duty'.

(3) A reasonably close casual connection between the conduct and the resulting injuries.

(4) Actual loss or damage resulting to the other.

So negligence ultimately is a matter of risk, that is to say, of recognisable danger or injury. Persons are supposed to meet with certain standards of conduct. This standard is supposedly based on what society demands of its members, rather than upon the actor's personal morality. A failure to conform to the standard is negligence, even if it is due to clumsiness, forgetful nature, an excitable temperament or even sheer ignorance. In other words, the state requires a person not to be awkward or a fool. In negligence, the actor does not desire to bring about the consequences which follow nor does s/he know that they are certain to occur or believe that they will. There is merely a risk of such consequences sufficiently great for a 'reasonable person' in his/her position to anticipate them and to guard against them. Risk can be defined as a danger, which is apparent or should be apparent, to one in the position of the actor.

Nearly all human acts, of course, carry some recognisable or remote possibility of harm to another. No person so much rides a horse without some chance of a runaway nor does any surgeon perform an operation without some chance of himself suffering a heart attack and messing up the operation. Those are of course, 'unavoidable accidents' for which there is no liability. As the gravity of the possible harm increases, the apparent likelihood of its occurrence needs be correspondingly less to generate a duty of precaution. Thus the standard of conduct which is the basis of the

law of negligence is normally determined by a risk benefit form of analysis by balancing the risk in the light of the 'social value' of the interest threatened, and the probability and the extent of the harm, against the value of the interest which the actor is seeking to protect and the expedience of the course pursued.

## Professional Negligence

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

Let us look at how in practical situations, the law applies to doctors. A doctor may, of course, contract to cure a patient, or to accomplish a particular result, in which case, he may be liable for breach of contract. This is not, however what generally happens. In the absence of such express agreement, the doctor does not warrant or ensure a correct diagnosis or a successful course of treatment and a doctor will not be liable for an honest mistake of judgement where the proper course is open to a reasonable doubt. But by undertaking to render medical services, even though gratuitously, a doctor will evidently be understood to hold himself out as having standard professional skill and knowledge. The formula which is used is that the doctor must have and use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing, and a doctor will be liable if harm results because he does not have them. Sometimes, this is called the skill of the 'average' member of the profession, but this is clearly misleading. For only those in good professional standing are to be considered; and of this it is not the middle but the minimum common skill which is to be looked for. If the doctor claims to have greater skill than this, as when the doctor holds himself out as a specialist, the standard has to be modified accordingly.

Of course, there are areas in which even experts differ. Where there are different schools of medical thought and alternative



methods of acceptable treatment, it is held that the dispute cannot be settled by the law and the doctor is entitled to be judged according to the facts of the school the doctor prefers to follow. This does not mean that any quack or a crackpot can let himself be known as a 'school' and so apply his individual ideas without liability. A school' must be a recognised one within definite principles and it must be the line of thought of a respectable minority of the profession. In addition, there are minimum requirements of skill and knowledge, which anyone who holds himself out as competent to treat human ailments is required to have, regardless of his personal views on medical subjects.

Since judges/juries are essentially lay people, they are held to be normally incompetent to pass judgement on questions of medical science or technique and so only in certain types of cases findings of negligence are given in the absence of expert medical evidence. The normal reluctance of doctors to testify against co-professionals has been obstacle to justice in the US and the UK and is likely to be so even in India. Now of course, in the US and the UK doctors also come forward to give evidence on behalf of patients. Also, where the matter is regarded as within common knowledge of the lay people, as when the surgeon saws off the wrong leg or where injury is caused to a part of the body not within the operative field, the judges often infer negligence without expert evidence. The cumulative effect of all this is that the standard of conduct becomes one of 'good medical practice' ie what is customary and usual in the profession.

This, of course, gives the medical profession a privilege denied to others, of setting their own legal standards of conduct, merely by adopting their own practices, except in certain cases like in the cases of sponges left in the patient's abdomen after an operation where the task of keeping track of them has been delegated by the surgeon to a nurse. Though this was and is still a routine practice, the doctor was found to be negligent.

In one of the earliest cases, an English court felt that the surgeon was liable as he had acted contrary to the known rule and usage of surgeons. What happens if the patient is injured because of the omission to carry out an available test, which is not generally conducted by doctors for such patients? In 1974 an

American Appeals Court was faced with this issue. Barbara Helling suffered from primary open glaucoma. This is a condition of eye where there is an interference in the nourishing fluid's flowing out of the eye. There can be a resultant loss of vision. The disease has few symptoms and in the absence of 'pressure test', is often undetected till irreversible damage is done. Helling contacted two ophthalmologists, Carey and Laughlin, at that time believing that she was suffering from myopia (short-sightedness). From 1959 to 1968 she consulted these doctors, who fitted contact lenses and believed that irritation caused in her eyes was because of complications associated with the lenses. For the first time in 1968 they tested the patient's eye pressure and field of vision. This indicated that she had glaucoma. By that time the patient, who was 32, had essentially lost her peripheral vision and her central vision was reduced. She filed a case for damages.

The doctors argued and proved that the standard of the profession did not require the giving of routine pressure test to persons under the age of 40 as the incidence of glaucoma is 1 out of 25,000 persons under the age of 40. They argued that since they had acted in accordance with the standard practice of the profession they had acted with reasonable prudence. The court, however, disregarded this defence. The judges held: "In most cases reasonable prudence is in fact common prudence, but strictly it is never its measure. A whole calling may have unduly lagged in the adoption of new and available devices. Courts must in the end say what is required: there are precautions so imperative that even their universal disregard will not excuse their omission". The court felt that despite the fact that a pressure test was not used generally by ophthalmologists, the doctors ought to have used it. Barbara received compensation.

The case is significant because the standard of care required of the doctors is widened. Normally, of course, the standard adopted in the profession would be acceptable as the standard required of each doctor. This case for the first time obliged doctors to conduct certain known tests even if they were not being conducted in the profession generally.

This case created a storm in the US. Attempts were made through courts and legislature to change the law laid down by



the case, but ultimately they have proved to be futile. However, the application of this case is only confined to a narrow field of possibilities and that the rule of 'general practice' within profession is still widely applied.

*Hospital Liability*: Can a hospital be made to pay for negligence of doctors, nurses and other staff. This is an issue of great importance in India. Often it is not possible to identify the person whose negligence led to injury. Take the example of a patient who is given saline by a number of doctors and nurses from time to time. A particular needle may not be sterilised causing gangrene. Can one then sue the hospital? Or as it often happens the negligent staff member does not have the means to pay. Can one sue the hospital and recover the compensation?

A case in point in the US was Darling vs Charleston Community Memorial Hospital decided in 1966. In November 1960, Darling, 18 years old broke his leg while playing college football. He was taken to emergency ward of Charleston Hospital and treated by Dr Meroander, who applied traction and placed the leg in a plaster cast. Soon after, Darling was in great pain and his toes which protruded from the case, became swollen and dark in colour. His condition kept worsening and ultimately the leg had to be amputated. The court held that the nurses had not checked sufficiently, and as frequently as necessary, the blood circulation in the leg. Skilled nurses would have promptly recognised the condition and would have known that it would become irreversible in a matter of hours.

The question was whether the hospital was liable. The judges held: "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and patients, but undertakes instead simply to procure them upon their own responsibility, no longer reflects the fact. The present day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting fees for such services, if necessary, by legal

action. Certainly the person who avails himself of hospital facilities expects that the hospital will attempt to cure him not that the nurses and other employees will act on their own responsibility". The hospital was made to pay damages.

The Darling case became a landmark decision in medical malpractice claims as it placed a direct responsibility on the hospital for the maintenance of an acceptable standard of care for patients. Subsequently, the scope of this decision has been widened and charitable hospitals have also been held to be responsible.

Is the hospital liable if the patient's infection is traced to blood products supplied during his operation? In a 1970 Illinois state case, the hospital was held to be strictly liable for supplying contaminated blood. A hospital will also be liable for negligence of any honorary doctors or specialists it calls, but not for private doctors called by the patients themselves. Hospitals, in same case have been held guilty even when their employees have acted in direct contradiction of the hospitals' instructions or prohibitions causing injury.

*Strict Locality Rule*: The standard of care expected of doctors is, generally speaking that prevalent in the profession. They are not only required to perform tests generally performed, but also to be informed sufficiently about the new developments in the field.

A hotly debated issue in the US and UK arose out of a presumption that the rural and small time practitioners would be less adequately informed and equipped than their big city colleagues. To adjust to this, the courts came out with a theory that there could not be any national standard of care but the standard varied from locality to locality. They applied the strict locality rule which meant that the standard of care expected of doctors depended on the general standard of that particular locality. However, in recent times this rule has been given up and national standard applied on the basis that "new techniques and discoveries are available to all doctors within a short period of time through medical journals, closed circuit television, special radio networks for doctors, tape recorded digests of medical literature and current correspondence course."



This situation is prevalent only in developed capitalist countries. In countries like India, it is very likely that when cases come up, the strict locality rule will be applied.

*Res Ipsa Loquitor*: Ultimately it is for the patient to prove that it was negligence which caused her/his injuries. Often it becomes difficult to do so for varied reasons like hiding of information by the doctors. What happens in some cases, however, is that after presenting all evidence, though the negligence is not proved directly, it is still pretty obvious that the patient could not have suffered injuries except through negligence. In such cases the legal doctrine of '*res ipsa-loquitor*' or 'the thing speaks for itself' is applied. Negligence is presumed to have been proved and the doctors held liable.

In a case decided in an American court in 1975, Anderson was admitted to hospital for a back operation. During the operation, the tip or cup of a forceps like instrument (angulated rongekur) broke while it was being manipulated in the patient's spinal cord. It could not be recovered and the patient suffered permanent injury. Anderson sued the doctor, the hospital, the manufacturer and the distributor. Each tried to push the blame on the other and it could not be proved as to whose negligence had led to this complication. It was not established whether the rongekur broke because of manufacturing defect, certain problems during transit or due to the doctor's negligence. If it was merely a case of determining negligence from amongst the hospital staff and doctors, then even without establishing who exactly was negligent, the hospital could have been saddled with damages. Here of course, the hospital was saying that it was not the neglect of staff or doctors which caused the rongekur to break but that of the manufacturer or dealer.

It was just not possible to establish what caused the breakage. The court, however, came to the rescue of the patient and observed, "In the type of case we consider here, where an unconscious or helpless patient suffers an admitted mishap not reasonably foreseeable and unrelated to the scope of surgery (such as cases in which foreign objects are left in the body of the patient), those who had custody of the patient, and who owe him

a duty of care as to medical treatment or not to furnish a defective instrument for use in such treatment, can be called to account for their default. They must prove their inculpability or else risk liabilities for injuries suffered". All of them were held jointly liable. The doctrine of *res ipsa-loquitor* has been extensively used in 'swab cases' where after the operation, an instrument is left inside the patient's body. It has also been used for other types of cases, for instance in the Canadian case of MacDonald vs York Country Hospital Corporation, the patient was admitted for treatment of fractured ankle and left with an amputated leg. Heavy damages were awarded to MacDonald despite there being no direct proof of negligence.

*Misdiagnosis*: A liability will be imposed when the doctor fails to conduct tests which a competent practitioner would have considered appropriate or when the doctor fails to diagnose a condition which would have been spotted by a competent practitioner. In Langley's case, the patient had returned from East Africa shortly before the development of symptoms. The general practitioner failed to diagnose malaria and this was considered as negligence. Similarly in Tuffil's case the patient had spent many years in a tropical climate, the doctor failed to diagnose amoebic dysentery which proved fatal. This failure to diagnose was held to be negligence.

A question which arises is whether a new doctor would have the same responsibility as a seasoned doctor? The law makes no distinction in this regard. In Wilsher vs Essex Area Health Authority case, the patient had been born prematurely and had been admitted to a special unit where extra oxygen was administered to him over a long period. His eyesight was badly affected as a result of a junior doctor's failure to monitor the supply of oxygen. The hospital was held to be liable.

In many cases it is a part of the duty of the doctors and nurses to predict that the patients may damage themselves as a result of their medical condition. For instance, in one case the patient had been admitted to hospital after a drug overdose. Although he had known suicidal tendencies, he was not kept under constant observation and he climbed on the hospital roof and fell incurring injuries, while the two nurses on duty were out of the ward. He was awarded damages of £ 19,000.



*Informed Consent*: One of the most rapidly growing medical malpractice litigation is in the areas of 'informed consent'. This concerns the duty of physician or surgeon to inform the patients of the risk involved in treatment or surgery. The principle here is the classical bourgeois democratic ideal of individual autonomy, ie that every person has a right to determine what will be done to her own body and the right to have bodily integrity protected against invasion by others. Only in certain narrowly defined circumstances can this integrity be compromised without the individual's consent. Surgeons and other doctors have to provide their patients sufficient information to permit the patient to make an informed and intelligent decision on whether to submit to a proposed course of treatment or surgery. So, even if a procedure is skillfully performed, the doctor may nevertheless be liable for an adverse consequence about which the patient was not adequately informed. Of course, the patient has to show a causal link between the non-disclosure and his/her injury by proving that s/he would not have undergone the treatment if s/he had known the risk of harm that in fact occurred. The courts believe that all patients, in retrospect, would say this and so even here they have evolved the criteria of 'reasonable patient' i e whether this hypothetical patient in the actual patient's place would have withheld consent to the treatment had the material risks been disclosed. This, of course, is problematic because the individual patient's characteristics are totally ignored. Slowly, the courts in the US are trying to incorporate even this subjective factor.

What risks have to be disclosed? All the material risks i e the nature of pertinent ailment, the risks of proposed treatment, including the risks of failing to undergo treatment, have to be disclosed. Even if the risk is a remote possibility it should be disclosed. However, unexpected risks may not be communicated. For instance, in an American case a patient suffered cardiac arrest during amniocentesis. There were no prior documented cases like this. The doctor was not held to be negligent. Even otherwise, there are cases where the risk disclosure may be precluded by an emergency situation or the patient's incapacity. In fact in the US all states have passed what are called 'Good Samaritan Laws' aimed at protecting

doctors giving emergency roadside treatment. The disputed issue is whether for the benefit of the patient, the doctor can withhold information from them. When a doctor feels that the patient will suffer mental shock or nervous breakdown if the risk is communicated. Such withholding is called 'therapeutic privileges'. But there is another school which believes that all information should be disclosed so that the patient can make up her/his mind in the light of all the circumstances. The courts are divided on this point.

A problem which has not arisen in the western countries but which can arise in India is if the patient is conscious and does not consent to a treatment which is necessary to save his/her life. Can forcible treatment be justified? In most of the western countries suicide is no longer a crime and so doctors cannot forcibly treat anyone. In India, of course, this question is likely to cause some problems.

The case of minors also raises a perplexing problem. Since minors are considered by law incapable of giving consent, the parents' consent has to be obtained. But what happens if a minor who is of understanding age gives instruction contrary to that of the parents? In one English case, a school girl aged 15 wanted an abortion but the parents refused to grant permission. The court held that the girl was entitled to abortion as she was capable of understanding its implications. Nowadays, at least before surgery, a patient is normally required to sign a consent form. But the patient can still prove that no consent or informed consent was taken and the doctor will then be liable to pay damages.

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

The first was decided by the Lahore High Court in 1935. R N Rao, a lawyer, suffered from high fever and sores on his face. Dr Whitamore, the civil surgeon, treated him. He diagnosed the disease as syphilis and gave injection of Sulphatab. Later Rao suffered from gangrene and had to have his fingers amputated. His eyesight was affected and he lost his strength. He had never had syphilis and he was informed that he had contacted peripheral neuritis because of a mistaken injection of arsenic. The court, however, did not find the doctor guilty. The reason given



was that though the diagnosis was wrong, specific carelessness was not proved. The court adopted a reasoning which would be totally unacceptable today. It did not go into the question of whether the doctor had performed the required tests before concluding that there was syphilis. Neither did it try to answer the question as to what caused the gangrene.

The second case was one decided by the Supreme Court in 1969. Anand met with an accident on the beach at Palshet in Maharashtra which resulted in the fracture of the femur of his left leg. The only treatment the local physician gave was to tie wooden planks on his legs for immobilisation. The following day he advised removing Anand to Pune for treatment. He also substituted splints for the planks. After that, in a taxi, Anand was shifted to Pune. Dr Joshi got him screened and found that he needed pin traction. He was then taken to Joshi's hospital. Joshi asked his assistant, Dr Irani to give Anand two injections of morphia and hyoscine HB at 1/2 hour interval. Irani gave only one injection. Anand was then taken to the X ray room, and after taking two X rays removed to the operation room. After about 1/2 hour when the treatment was over, he was shifted to the room he was allotted. On an assurance given by Joshi that Anand would be out of the effect of morphia in 1 1/2 hours, Anand's father went back to his village. Anand's mother remained with him. After about an hour, she found that Anand was having difficulty in breathing and was coughing. The doctors were called, Irani, gave emergency treatment upto 9 pm when the boy died. Joshi issued a certificate saying that Anand had died of embolism.

Joshi was sued. Anand's father contended that Joshi did not perform the essential preliminary examination of the boy before starting his treatment and injecting morphia. It was also alleged that while putting the leg in plaster manual traction was used, using excessive force with the help of three men though such traction is never done under morphia alone, but under proper general anaesthesia. Joshi in his reply denied the allegations by saying that no general anaesthesia was given considering the exhausted condition of patient. It was decided to immobilise the fractured femur by Plaster of Paris bandage and no excessive force was used. However, on evidence the court felt that Joshi was negligent. It came to

the conclusion that it was due to shock resulting from reduction of fracture attempted without taking the elementary precaution of giving anaesthetic to the patient.

Speaking about the duties of doctors, the court repeated the British and American law saying "The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient, owes him certain duties, viz a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of these duties gives a right of action for negligence to the patient".

The third case was decided by the Bombay High Court in 1975. This case read like a doctor's apology. Philips India had appointed a doctor to give treatment to the employees. One employee contracted small pox and died. The doctor had treated him for venereal disease. The court felt that there was a genuine error of judgement and since the particular variety of small pox was fatal, the doctor in any case could not have done much. The problem with the case is not that it exonerated the doctor, especially considering the peculiar facts of the case, but the extent to which it sought to protect doctors. The court expressed the view that negligence of doctors should be interpreted much more narrowly than negligence of others, ie the doctor has to be placed on a high pedestal and held to be negligent only if it is totally unavoidable. Of course, this case is not likely to have any impact on subsequent cases, but still, it shows the attitude of the judges. The important point decided by this case, however, was in holding that if the doctor had been proved to be negligent, the company which employed him would also automatically be negligent. All the three cases relied only on English law books, by of course picking and choosing what suited the court's convenience.

## Politics of Torts

A proper understanding of the rise of 'negligence law' requires an analysis of the development and rise of the Tort law. An extensive application of Tort Law is found only in developed



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

In an earlier period, law was largely preoccupied with personal status, control over resources (primarily land) and the development of contractual relations (mercantile capitalism). Industrial capitalism transformed the entire social structure, engendering urbanisation which enormously increased the frequency of interaction among strangers. Important, because unlike acquaintances or intimates, strangers would have less incentive to exercise care not to injure one another inadvertently and would find it more difficult to resolve the differences when injury occurred. At the same time interaction between friends and intimates became progressively limited, ultimately confined to the nuclear family. Intimates commit most intentional torts. But within the nuclear family they are rarely resolved by the legal system, (a) because they would destroy the relationship, and (b) the persons committing torts are sufficiently powerful.

Industrialisation gave capitalists the power to effect extensive damages, first through unprecedented physical force (factories, railways, etc) and now through toxic chemicals. Concentration of capital and mass production increased the number of workers, consumers and others who might be harmed by me capitalists' indifference or miscalculation.

Capitalism also shapes the experience of injury. It must create a proletariat which must sell its labour for wages to live. It simultaneously destroys the obligation of mutual support outside the nuclear family and pays those within it who are gainfully employed at a level of wages too low to support non-productive members. As inability to work becomes tantamount to destitution or dependence upon charity, the core of damages is compensation for loss of earning capacity.

Second, capitalists, middle classes and even industrial workers acquire consumer goods which require protection against inadvertent destruction.

Third, the family is no longer able to care for injury or illness, partly because members must seek employment outside and partly since care itself is commodified and monopolised by the emergent medical profession. As the monopoly allows professionals to command high fees, injuries 'cost' a great deal more.

Finally, commodity form is progressively extended to non-productive experience.

Capitalist Tort Law exploits and alienates the victims in ways parallel to exploitation and alienation of labour. In precapitalist society, injury, like work, creates use value; it elicits cure from intimates who are motivated by concern and promotes demand for apology backed by threat of retribution. The capitalist state which asserts its monopoly of force to obstruct the latter response, also creates a market for injuries in torts and legal system. It separates, through the legal profession, tort victims from means of redressing their wrongs and medical profession; disabled victims and intimates from caring for the ill. In each instance, a faction of the ruling class mobilises the power of the state in its own interests to protect the monopoly of expertise of lawyers and physicians. The lawyer then combines legal expertise with the victim's injury (as the capitalist combines capital with the workers' labour) to produce a tort (a commodity) that has exchange value both in the state created market (the court) and in the dependent markets (negotiated settlements).

As capitalists have to maximise profit in a competitive market, they must sacrifice the health and safety of others. Another reason why capitalism fosters injury is that it must expand its market and increase consumption; torts contribute to it just like planned obsolescence and warfare. Tort Law, following legal liberalism, eliminated formal legal discrimination. So, with its development discrimination between patients who are victims of charitable hospitals and those of noncharitable hospitals, etc were eliminated. But it could not and cannot remove certain deeper inequalities.

First, of course, the inequality in the incidence of injury and illness: capitalists and professionals are subjected to hazards different from those suffered by workers at the workplace or



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

Secondly, class and gender will affect the extent to which and the way in which the experience of injury is transformed into a claim for legal redress, the sense of entitlement to physical, mental and emotional well being (women only recently began to legally resist abuse by their husbands, workers are only now coming to view hazards at work place as a negotiable demand), the feeling of competence to assess a claim, the capacity to mobilise legal process, ability to overcome delay, etc.

Third, the law also discriminates in the availability and generosity of the remedies it offers, the biggest difference being between tort damages and other compensation systems. An industrial worker is far more likely to be injured at work than a person from another occupational category, such injuries are relegated to workmen's compensation, which pays only a fraction of tort damages and rejects altogether certain tort categories. Other oppressed categories, women, children, dalits, religious minorities, are also excluded from tort recovery. They are most frequently the victims of violent crimes and other social crimes whose assailants are either unidentifiable, unavailable, financially irresponsible or simply too powerful. Women and children injured by relatives are left without any remedy.

Another type of discrimination is internal to the tort system. Pecuniary damages are paid on the basis of income of the person. Even the damages for pain and suffering are often expressed as multiples of pecuniary damages. So a poor person will get much less damages than a rich person. Women will get much less than men.

## Production of Illness

Capitalist Tort Law systematically encourages unsafety. The dynamics of capitalism, the pursuit of profit impels the enterprise to endanger the workers, its employees and those who inhabit the environment it pollutes. As the cost of safety reduces profits, a capitalist must be as unsafe as he can get away with being.

Apparently the Tort Law curbs these destructive tendencies through the threat of damages. But this is not what actually happens.

First, compensation is paid on the basis of the status of the victim not of the offender, the doctor for instance.

Second, the insurance mechanism goes a long way in virtually nullifying the burden on the offender.

Third, as seen above, due to the discriminatory aspect of Tort Law many injuries and victims are excluded from its purview.

In fact, Tort Law encourages the entrepreneurs and the professionals to evade the consequences of carelessness not to enhance safety. Their response to the threat to tort liability is to strive to externalise accident costs by concealing information. For instance, the market deterrence, by mandating the payment of money damages, subverts collective efforts to exert control over safety, damages are paid only for an injury caused by the offender's act. This means that unsafe conduct causing no injury is not deterred and that the legal attention is focussed on the temporarily delineated act of an individual rather than on the ongoing activity of a collectivity. Capitalist Tort Law, like capitalist medicine, is obsessed with individual care at the expense of collective prevention because capitalism creates a market only for the former.

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

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



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

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

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

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

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

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

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

# Postscript

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

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

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

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

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

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

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

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



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

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

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

***Amar Jesani***
*Mumbai, July 31, 1996.*