Law, Medicine and the People

THE purpose of law, it is said, is to 'regulate' human activities in a society and the medical world concerns itself with "improvement in physical and mental health of the people and the prevention, diagnosis and treatment of illness". It is, therefore, quite natural that laws relating to the medical world need to be examined and modified/rectified from time to time in relation to their impact on the society and people they aim to regulate.

The Indian legal system and laws, in particular those related to medical practices etc., are borrowed to a great extent from the British system. It is pertinent to compare their impact on the people(s) in terms of their meaningfulness to them. It would be both cumbersome and meaningless to make a comparison of each law (related to medicine) and examine its 'regulatory impact' on the society. Besides, there are laws relating to medical practice that are only remotely concerned with the general public and are, therefore, not of consequence here. In fact it might serve to consider here the different entities and their functions and the laws pertaining to them.

Doctors and Laws

Medical practioners must 'register' before they can practice and collect fees for their advice and registration is subject to minimum standards of qualification. Under the Medical Act these responsibilities are given to respective Medical Councils. These Medical Councils are also empowered by the act to cancel the registration of a medical practitioner from the Medical Register if there is "serious professional misconduct" and there is a Medical Disciplinary Committee set up for this purpose. In UK several registrations have been erased either because it is "necessary for the protection of members of the public or in the best interest of the person suspended." And there is usually a very meaningful debate on the issue in medical journals, which itself acts as a deterrent for others. Such erasure of registration of medical practioner is almost absent so far as the Medical Council of India is concerned. However, the absence of erasure need not be construed to mean that things are above board in India. Adultery, improper association, negligence, and advertising are some of the issues on which registrations can be erased and many of our practitioners violate at least some of these and yet the MCI does not seem to be stirred enough to take action.

To take another example, according to the Act: "Nothing in the act shall extend or be construed to extend to prejudice or in any way affect the lawful occupation, trade or business of chemists and druggist and dentist or the rights, privileges or employment of duly licensed apothecaries so far as they extend to selling, compounding or dispensing medicines". Yet it is almost a universal practice for general practitioners in India to dispense drugs and charge for the same. Neither the MCI not the state have taken any action on this.

Further, "It is the duty of every registered practioner to bring to bear upon all his professional activities that standard of skill and knowledge which is to be expected of a practitioner of his experience and status and of comparable standing to him. It is also his duty to exercise reasonable care in his treatment of a patient. If the failure to exercise the necessary degree of skill or care results in injury to the patient, he will have a right of action for damages. Whether reasonable skill or care has been exercised in a particular case is a matter which has to be considered in relation to the facts of each case." No branch of the law affects the practice of medicine more strongly than the law of tort (civil wrong) under which negligence is perhaps the most talked about.

The glycerol tragedy in the J J Group of Hospitals has highlighted the issue of negligence. There can be no doubt about the fact that there was negligence on the part of everyone including the doctors of the hospital and yet is it not strange that the MCI has chosen to remain silent on the issue? It is in circumstances such as these where the ethics and rules enforcing bodies such as the MCI refrain from acting that the absence of people's participation in such matters become evident. What does one do when professional bodies fail to act?

Yet another example is that of the Bhopal disaster where the gas-affected people were 'denied' the antidote sodium thiosulfate for reasons that are still unclear today. Doctors' obligation, the Council's obligation and the state's obligation are evident by their absence.

Another issue that needs to be discussed here is the one related to informed consent. "A doctor has no right to do anything to a patient without his consent except in the case of emergency when he must exercise his discretion. The securing of a signature to a consent should not be allowed to become an end in itself. The most important aspect of any procedure must always be the duty to explain to the patient or relative the nature and the purpose of the proposed operation and thus to obtain a fully informed consent. In our country this should be even more important (though admittedly also more difficult) since there is so much illiteracy and lack of information. But it is common knowledge (though difficult to prove) that informed consent is reduced to a mere signature-obtaining exercise. The matter becomes even more serious when, to meet the family planning targets, healthy women and men are subjected to sterilisation operations.

Drugs are another entity subject to standards. Our drug laws are very similar to the British ones. An additional regulation in India is the Drug Price Control Order, which sets norms for prices of drugs. Despite

this, unlike in UK, the bulk of 40,000 to 60,000 formulations put into the market by over 9,000 manufacturers, are irrational, useless or even hazardous in some cases. A significant number of them are sub-standard. Doctors' prescriptions are often found to contain superfluous and unnecessary drug formulations, evidently to favour the drug companies' representatives. One report indicates that in Tanzania, there is one drug company representative for every four doctors (see Mukarram Bhagat's *Aspects of Drug Industry in India'*). In India, with 9,000 drug companies, the situation is very much the same. (In UK, the ratio is 1:20). Clearly the Indian patient pays a great deal more for medicine and gets much less value for it. Laws and the legal system need to take cognisance of this and ensure regulatory mechanisms to remedy this situation. What is more, the Bangladesh drug policy has already unequivocally demonstrated that the expenditure on medicine can be reduced and more 'value' made available to the patients and has also proved to be sustainable.

Health Services and Law

If there is similarity in the British and Indian laws in respect of drugs and registrations of doctors, the hospital services policy is different. In UK, under the National Health Services Act 1946, comprehensive health services are made available to the people. This includes a scheme of social insurance, and covers an overwhelming populace of the country. In India there is no comparable legislation and the state health sector incorporates the medical services including CGSS and ESIS. Indeed there are public hospitals and dispensaries which are supposed to deliver medical services free or at very nominal fees but in effect are found wanting. There are no minimal standards clearly specified for commissioning of hospitals or dispensaries and it is not unusual to find Primary Health Centres being reduced to the structure of bricks and mortar. Hence even the Health Policy promises to have at least one PHC for every 30,000 population, this goal is not attained and at times even when there is a PHC existing, it could hardly be functioning. Comically hotels and restaurants of some cities in India are graded according to the services they make available but not the hospitals.

The quality and quantity of health/medical care made available to the people is hopelessly inadequate and with the paucity of resources it is clearly evident that radical and pragmatic legislative and policy approaches are necessary. Strangely it is the countries where health/medical care is of a high standard, which are clamouring for 'radical' changes in their system to be even more effective e g, in March 1987, the British Medical Association recommended that the government introduce a 'no-fault' compensation scheme based on the Swedish model. Diana Brahams (*Lancet*, January 2/9, 1986, p 43) explains "In my view the term 'no fault' is inaccurate; in truth the scheme provides compensation without apportioning blame for unexpected adverse results arising from medical treatment in which error was an important factor. A failure to act, or to act in time, may also be compensable."

It is interesting to compare medical malpractice perspective in US and UK (where consumer awareness is high) before one takes stock of the situation in India. In the United States (as everyone knows) the suits pertaining to medical malpractice are far more frequent than those in United Kingdom. Lois Quam *et al* of the Centre for Socio-Legal Studies, Oxford, have reported in an excellent study in this respect (*BMJ*, vol 294, 1987, pp 1529-1532 and vol 294, 1987 pp 1597-1600) that "the reasons for this are related to American health care and social security systems. "Relative to United Kingdom, there are fewer barriers of access to the courts." "The differences between the National Health Service and American health services are gross and well recognised. The close relation between the cash nexus of private practice and high rates of litigation in the USA is less understood." Patients who are paid directly for their health care, through a mixture of insurance premiums and contributions out of pocket, seem more likely to feel aggrieved when treatment fails. Moreover, litigation is fuelled by the sheer cost of extra care after an iatrogenic injury or treatment.

In principle the National Health Service (UK) seems likely to reduce claims in at least four ways: There is no direct cost to the patient for extra medical care to remedy injury; access to care is guaranteed throughout life; there is no direct financial relation between doctors and patients; and the system of referrals restrains specialists while encouraging loyality between patients and their general practioners."

It is important to note that in both the countries, there is adequate provision (monetary or by services) for medical and nursing care for the remainder of life. In our country medical and health-care is grossly inadequate and despite a number of medical malpractices there is hardly any litigation or effort to redress injustice caused. Even when there is litigation, the odds are heavily pitted against the patient in more ways than one: (i) there is a strong nexus amongst doctors to 'protect' one another in the event of a case in the court; (ii) patient record is not available to the patient (unlike in Sweden) for proper presentation of the case; (iii) and lastly the cases drag on (very often) for such an extraordinary length of time that most people find it beyond their means to 'sustain' litigation. Although the Legal Services Authority Bill has been passed under which free legal services are made a statutory right the bill has grave limitations and is self-defeating. That it does not provide for mass participation and nor does it attempt to provide relief beyond the monetary (see Krishna Iyer's Comment in *From the Lawyer's Collective*, November 1987). Thus, legal provisions cannot be an end in themselves. While legislation provides for the possibility of ensuring justice without prejudice both its content and form are limited to the socio-political context of particular societies. Its extension and implementation is a consequence of people's movements.

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