



MEDICAL PROFESSION AND THE CONSUMER PROTECTION ACT

I Introduction

TILL RECENTLY the patients did not have any effective adjudicative body for getting their grievances redressed. The Indian Medical Council Act, 1956 as amended in 1964, provides in Section 20(A) that regulations made by the Council may specify which violations shall constitute misconduct. Professional misconduct so specified can be visited by the punishment of suspension or even deletion from the rolls of the erring doctor.

This arrangement does not have the desired deterrent effect because Council members are prone to play soft *vis-a-vis* their conferees. Secondly, the Council was available only at the State Headquarters, in that way hardly accessible to the majority of patients. At any rate the Council has no power to award compensation to the patients for the injury sustained.

There are of course provisions in Civil and Criminal Law offering remedies to aggrieved patients. But criminal law was pressed into service only in cases of death and even in that respect prosecution was not always alert. The civil law remedy was available in principle because any sub-court could be approached for getting damages. But the patients have to pay court fees. The trial was long on account of the elaborate rules of procedure and strict principles of evidence applicable before those courts. This involved delay and heavy expenditure, which deterred the beleaguered patients. The resulting position was that the doctors were practically assured of immunity in case of misdeeds. However, it is to be said that their community as a whole behaved much better than other corps.

II Jurisdiction

With the advent of Consumer Protection Act, 1986 creating consumer disputes redressal agencies (C.D.R.As) there is drastic change. This was immediately resented by the community of doctors who raised their shields and challenged the applicability of the Act to them. The reason, put forth by them was threefold.

The first set of reasons was regarding the interest of the patients. There could be unwillingness on the part of doctors to treat high-risk cases or cases of emergency for a fear of being dragged to the consumer in case anything goes wrong. There would definitely be a rise of cost on account of the insurance which the doctors would be compelled to take, moreover over-investigation in order to be on the safe side also involves high costs, which would ultimately be borne by the patients.

The second set of reasons referred to was the nature of the relation between the doctor and the patient. There has ever been a relation of trust and faith between the doctor and the patient in India. The function of the doctor was a noble and service



oriented one and not to be equated with that of traders solely aiming at profit motive.

The third set of reasons was regarding the capability of the adjudicative bodies created by the Act to deal with medical cases. There could be no doctor in the adjudicative body and moreover two members out of the three are non-judicial and could constitute a majority whose decision could be erratic on account of their not being either medical or legal experts.

The reasons put forth by the community of doctors though some of them were based on facts could not outweigh the advantages provided by the remedies under the Act. Doctors have not also been able to point out any case of unfair or incongruous decision rendered by the adjudicative agencies under the Act, which would have been caused by the ignorance of medical realities.

The matter was set at rest by the Supreme Court in *Indian Medical Association v. V.P. Santha and others*¹. The Supreme Court after going deeply into the provisions of the Consumer Protection Act held that the language used by the law-maker was wide enough to cover the services rendered by doctors as well. In fact as per Section 1(4) of the Act all services except those excluded by way of notification of the Central Government will be within the purview of the Act. As per Section 3 of the Act the existence of alternative remedies will not be a bar for approaching the adjudicative agencies under the Consumer Protection Act.

The cases of exclusion are those provided under section 2(1)(o), that is to say, service under a contract of personal service and service free of charge. The Supreme Court held that the contract between the doctor and the patient was a contract for services and was not a contract of personal service, which implied a relationship of master and servant. Therefore in respect of any medical service availed of after paying for it, any grievance may be brought before the agencies under the Act. The Supreme Court however held that, if only a token payment was made, that would not amount to 'consideration' and that the service should be considered as free of charge and therefore outside the jurisdiction of the agencies under the Act.

The Supreme Court went a step further in holding that persons who were offered services free of charge in a clinic in which most of the patients were required to pay, would also be covered by the Act. This raised many eye-brows. Those categories of persons, strictly speaking do not come within the definition of the word 'consumer' in the Act as beneficiaries, because they do not avail of the services rendered to them with the approval of those who have paid for services rendered to them only. The service rendered by a medical clinic may have a charitable motive. However there are reasons which go in favour of the stand taken by the Supreme Court. The clinic may entertain those poor patients, in order to promote its clientele; it may even use them for clinical trials.

It is to be noted that in case of a refusal by a doctor to a request for assistance the matter cannot be brought before the agencies under the Act since in those cases the doctor would not have taken any fee. The relief in those cases is only under criminal law or before the Medical Council.

1. A.I.R. 1996 S.C. 550.



The question arose whether a matter involving complicated questions of law and facts requiring detailed investigations could also be entertained by the agencies under the Act. The National Commission in *R.P. Gopinath v. S.K.C. Medical Foundation*² affirmed that they have to be entertained. The Supreme Court in the above mentioned decision³ observed that in cases involving complicated issues requiring recording of evidence of expert the complainant can be asked to approach the civil court. It is to be noted that the Apex Court did not hold that in such cases the consumer agencies ceased to have jurisdiction; it only indicated a possibility in the interest of the patient.

Once the jurisdiction has been conferred on an adjudicative body, it has to deal with it, however complicated the matter may be. Further, since the elaborate rules of procedure and evidence prescribed for a civil court do not apply for the C.D.R.As and since the issues before them are relatively simple, there cannot be really complicate cases. If attempts by advocates to sidetrack the issues are resisted, all matters could be dealt with satisfactorily without using much time.

It is also to be said that the agencies under the Act have been vested all the powers of a civil court for the purpose of enquiring into the matter. Further the agencies presided over by at least by a District Judge would not lack expertise in collecting and analysing evidence. Of course if the patient prefers to take his matter before a civil court that is altogether a different matter, but a patient cannot knock at several doors for the same cause of action, simultaneously or successively.

The doctor who fails in his defence will have to pay cost to the complainant as per section 14(1) (c) of the Act. But there is no provision to direct the complainant to pay cost if he fails. However, if the consumer resorts to frivolous or vexatious demand he may be ordered to pay to the opposite party costs not exceeding Rs.10, 000/-. This provision received application in *K. Jayaraman v. The poona Hospital and Research Centre*⁴.

III Deficiency in service

The relief afforded to the patients by the Consumer Protection Act is based mainly on the concept of deficiency in service. It is defined in the Act under section 2(1) (g) as follows: -

Deficiency means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service

In the definition there is reference to law and contract. There is no law on the matter except perhaps a few provisions. There are also usually no specific terms of contract between the parties though the relationship is one of contract. Therefore

2. (1) 1994 C.P.J. 147 (N.C.).

3. *Supra* note 1.

4. 1994(2) C.P.R. 31 (W.C.).



deficiency, if any, has to be ascertained with reference to the canons relating to medical treatment. The doctor is expected to provide the treatment agreed to, tacitly or expressly, according to the established medical procedure. He has to do it with the required skill, knowledge and competence. The care expected is what an average doctor would do in the same circumstances. When the service rendered falls short of that requirement, there will be deficiency.

When two courses are open in a case, the doctor would not be at fault if one were chosen in preference of the other, even if ultimately, for unforeseen reasons, the course chosen has led to wrong results.

One cannot ignore the fact that the same service is offered at different rates. So, skill, competence, investigation and amenities will be obviously proportionate to the rate and the quality is expected to vary accordingly. So the rate determines the quality agreed to. However, the basis service should not be short of the medical requirement.

Apart from providing treatment, the doctor has to inform the patient. The information should be adequate not cursory. In case of risky and costly treatment, if the understanding capacity of the patient is deficient it is necessary to get a relative or a friend to whom the course of treatment is explained unless there is urgency which does not permit calling a third person. In such case of urgency, the explanation should be given at the first opportunity to the concerned person. In all cases the doctor is duty bound to give all the extra information asked for. He has also to enlighten about the natural course of the illness if no treatment is given. The task of information has to be continued throughout the treatment whenever necessity arises.

Where two courses are open the advantages and disadvantages of both should be explained in respect of the length of the treatment, risk, success rate, side effects, cost, etc. and there should be no attempt to influence the patient according to the personal preference of the doctor or the surgeon.

The duty of full information finds however its limit in the therapeutic privilege as per which the doctor has to withhold information to avoid some disastrous psychological shock. The criterion governing the privilege shall be as per the established medical procedure. When there is difference of opinion on equal strength in the field, the doctor will naturally choose according to his own conscience; he will not be at fault if he has chosen one course instead of the other.

There are cases where, in addition to information, consent is required. This should not be reduced to a sham formality. Consent in a printed form where only the name and the nature of the treatment in technical terms, often with the help of initials, are written by the doctor, may not amount to a real consent. Consent preceded by a proper information may be expressed in a printed form but it should be in a language known to the patient and it should be legibly filled. The doctor should ensure that the patient or another person close to him has given consent after reading the form and being aware of the essentials of the treatment or surgical intervention.

So, deficiency may be in respect of treatment, of information or of consent. The relief for deficiency is either to have it removed or to get the charges refunded, as per Section 14 of the Act. The refund of charges may not be worth asking when



charges paid are very low. Such persons would not approach the agencies under the Act, but there are more and more cases in which service charges are sizeable so that they may even amount to Rupees one lakh and above. In such cases the relief will be substantial. If the deficiency is not total the adjudicating agency may order the return of only a fraction of the charges paid. So, the reliefs provided in law in case of deficiency are not negligible. The possibility given to patients to assail instances of deficiencies is bound to reduce them, improving thereby the dispensation of medical service in general.

IV Negligence

The Act in its section 14 provide for two separate reliefs, one for deficiency (14c and e) and another for injury caused by negligence (14d). In case of failures or misdeeds by the doctors, patients may ask for both the reliefs or only one of them according to the facts of the case. Whatever is desired has to be pleaded clearly and established. Whilst deficiency is defined in the Act, negligence has not been so defined. So the meaning attributed to that term in the law of torts will apply. There is a risk of confusion between deficiency in service and injury by negligence, since there are similarities between them. However reliefs being clearly distinct, it is imperatively necessary to distinguish the one from the other.

The Punjab & Haryana High Court in *Dr. Ravinder Gupta v. Ganga Devi*⁵ has observed that the deficiency under consumer law undoubtedly includes what is negligence in the law of torts, but it is somewhat wider. Distinction between deficiency of service and negligence has also been brought out in a decision of the State Commission of Pondicherry dated 17.10.97 in *V. Vassandacoumary v. Dr. T. Ramachandrudu*⁶. The line of demarcation between the two notions will get more precise when the C.D.R.As decide more cases on the point. Pending that process or an authoritative pronouncement by the Supreme Court on the difference between the two notions one may venture to indicate some distinguishing features.

- In all cases of negligence there will be deficiency, but in all cases of deficiency, negligence may not be present.
- Deficiency may be the result of inability, lack of competence or inadvertence; whereas carelessness and indifference would cause negligence. Negligence would thus disclose a state of mind conducive to the causation of harm.
- Deficiency may occur in spite of the doctor but negligence does not happen that way.
- While deficiency may be gathered easily from the result, negligence may have to be gathered from the actions or omissions of the doctor.

Let us quote some instances of negligence. Delegation of responsibility to a junior with the knowledge that the junior is incapable of performing the task properly was held to be negligence by the Supreme Court in *Spring Meadows*

5. 1993 (3) C.P.R. 255.

6. C.P.J. 1998(3) at 227.



*Hospital & Am. v. Harjol Alhuwalia*⁷. The following acts were found to amount to negligence by the National Commission in *Harjol Ahluwalia v. Spring Meadows Hospital*⁸

- Misreading of a prescription by a nurse,
- Nurse giving an intravenous injection without the direct control and supervision of the resident doctor,
- Hospital entrusting the work of a nurse to a non-qualified person,
- Even a bad handwriting of a doctor resulting in the administration of wrong medicine, may make the doctor liable to pay compensation for the injury, if any, caused by such medicine.

Now let us turn to the determination of the amount of compensation for negligence. Whereas all the other reliefs are determined by the Act itself this one is left to the appreciation of the adjudicating agencies. The Act rests content with saying: "to pay such amount as may be awarded by it as compensation to the consumer for any loss or injury suffered by him due to the negligence of the opposite party". This means that the C.D.R.As need not compute accurately the loss, it will rather award a certain amount taking into account all the circumstances of the case.

The discretion as given has lead to much variation from one forum to another as regards the amount awarded by way of compensation. Of course the amount is bound to vary according to the dimension of the loss. But one fact, which is noticed, is that for the same injury of loss, the amount awarded by way of compensation has varied from Rs. 1,000/- to Rs. 10,00,000/-. Let us proceed to see how this may be remedied.

Since the matter is within the domain of the contract there is no room for exemplary or nominal damages. The aggrieved person is entitled to real compensation. The doctor found negligent need not pay for others' faults. Both parties should see it as compensation for injury and not penalty inflicted for wrong. The adjudicating agency should also have the same attitude. It should not act out of indignation however disastrous may be the result of negligence. Extra-ordinary circumstances unforeseeable by the doctor and independent from his action, which have aggravated the injury are not to be taken into account. Those circumstances are beyond the aim of the Act which is to protect the patients against the failures of the doctors and not against the other malefic forces. The average loss that a doctor could reasonably have anticipated may be a good indicator.

The factors to be taken into account are the age of the patient, his state of health, the rate of fees paid and other facts, which have been disclosed to the doctor. Certain injuries are not easy to compute in terms of money like body pain mental agony and loss in life. There are two methods of assessment: global assessment to the best of the judgement of the adjudicating body, which consists of at least three persons, or computation of damages with the help of some yardsticks. The second

7. C.P.J. 1998(1) at 2.

8. C.P.J. 1997(2).



course has the appearance of being more accurate. But the yardsticks are not easy to be determined properly and may lead sometimes to grave errors. The preference of the agencies is now for global assessment.

The question arises whether there can be liquidated damages, since we are in the domain of contract. This may appear shocking at first sight in the field of health. But it would have the advantage of avoiding the parties to fight on the value of the injury caused and of saving time for the agencies because at any rate in spite of the best efforts, it will be difficult to reach an exact evaluation. So clinics may perhaps work out the rate of liquidated damages, which will be allowed by them for cases of current occurrences, taking into account the decisions of the courts already available. Those rates would be accepted by the adjudicative agencies, if found reasonable and if they have been made known to the patients beforehand. This will bring about some amount of uniformity in the matter.

V Conclusion

With the advent of the Consumer Protection Act there is better protection for those who pay for their medical services. Since their number is on the increase the coverage will also increase. But two categories remain excluded, those who are denied service and those who cannot pay for the service. There were attempts to bring the last category, which constitute the vast majority within the jurisdiction of the agencies, and it was rejected as contrary to the scheme of the Act. In fact, that category of patients is catered for by philanthropic institutions and Government hospitals. Steps have to be taken in both the cases for a better supervision and a therapeutic audit in order to avoid mishaps.

As far as doctors are concerned whatever may be their reasons against the Act, there is no denying the fact that medical service is rendered more and more on commercial line and the treatment is becoming more and more costly. The adjudicating agencies offer sufficient guarantee of justice to them on account of appeals and revisions provided for. They may also take some preventive steps. The first one is to be careful. They may also refrain from dealing with cases beyond their competence and equipment. Of course they will not sent away a person in need of an urgent medical treatment. When in spite of all precautions, a case is filed before a C.D.R.A. the best defence of the doctor is the case sheet, which has to be kept genuinely with entries now and then of the observations and treatment.

But doctors may still have a legitimate grudge. When a complaint is taken on file, it may receive publicity tarnishing the reputation of the doctor concerned, even if ultimately the complain fails. This may perhaps be obviated by making conciliation mandatory in the agency before taking the complaint on file. Secondly medicine may be included as one of the qualifications prescribed for being a member of the C.D.R.As. When given an opportunity to sit in judgement over the acts of other professionals, doctors will reconcile themselves with others probing their performance.

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