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INDIAN MEDICO LEGAL & ETHICS ASSOCIATION

Aims & Objectives

- To promote, support and conduct research related to medico-legal, ethical and quality care issues in the field of medicine.
- To help, guide, co-ordinate, co-operate and provide expert opinion to the government agencies, NGO, any semi-government, voluntary, government agencies, legal bodies / institutions and judiciary in deciding settled or unsettled laws or application of laws / rules related to medico-legal or ethical issues.
- To train the medical professionals in doctor-patient relationship, communication skills, record maintenance and prevention of litigations.
- To promote and support the community members and individuals in amicable settlements of the disputes related to patient care, management and treatment.
- To provide specialized training in related issues during undergraduate or postgraduate education.
- To organize conferences, national meets, CME, updates, symposia etc related to these issues.
- To identify, establish, accreditation and promote organizations, hospitals, institutes, colleges and associations working on the related and allied issues.
- To promote goodwill, better care, quality care, professional conduct, ethical values.
- To establish and maintain educational institutes, hospitals, medical colleges, libraries, research centers, laboratories etc. for the promotion of its objects and to provide scholarships, fellowships, grants, endowments etc. in these fields.
- To print and publish the bulletins, books, official journal / newsletters or periodicals etc on related and allied subjects.
- To co-operate, co-ordinate, affiliate and work with other bodies, agencies or organizations to achieve the objects.

Consumer Protection Act 1986 - Boon or Curse for Medical Profession?

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An average Indian consumer is noted for his patience and tolerance. Perhaps because of these two traditional traits and due to the influence the Mahabharata, the Ramayana and the Bhagavad Gita and various other religious discourses, he considers the receipt of defective goods and services as an act of fate or unfavorable planetary position, when a new product purchased by him turns out to be defective from day one, he takes it reticently, blaming it on his fate or as the consequence of the wrongs committed by him in his previous birth. These traditional perceptions have influenced traders and service providers for exploiting the consumer.

In view of above perception and exploitation of consumer, in the thirty seventh year of the republic of India, The Consumer Protection Bill was introduced in the Lok Sabha on December 5th, 1986. The Consumer Protection Bill, 1986 was passed by both the Houses of Parliament and it received the consent of the President on 24th December, 1986. It came on the Statutes Book as the Consumer Protection Act, 1986. The motive of CPA 1986 was to ensure protection of the interest of consumers from exploitation and for the purpose to make provisions for the establishment of Consumers Councils and other authorities for the settlement of consumer's dispute and for matters connected therewith. (1)

It extends to the whole of India except the State of Jammu and Kashmir.

- Consumer Protection Act, 1986 is an important Act in the history of the consumer movement in the country.
- Consumer Protection Act, 1986 is mile stone in the history of socio-economic legislation and directed towards public welfare and public benefits
- It was drafted to provide the better protection and promotion of consumer rights through the establishment of consumer councils and quasi-judicial machinery.

The Amendments in the Acts (2 & 3)

1. The Consumer Protection (Amendment) Act, 1991 (34 of 1991).
2. The Consumer Protection (Amendment) Act, 1993 (50 of 1993).
3. The Consumer Protection (Amendment) Act, 2002 (62 of 2002).

The Consumer Protection Bill, 1986 was enacted for the promotion and prevention of the consumer's rights. These rights are as follows-

- Right of Redressal
- Right to Information
- Right to Choose
- Right to be Heard
- Right to Safety

Factors for Enactment of Act

- Industrialization
- Urbanization
- Deficiencies in services.
- Malpractice such as Adulteration
- Shortage or Non availability of essential goods at reasonable price.
- Lack of control on the quality of the consumer goods.
- Global markets and open Economy

Complaint under CPA, 1986

- A consumer for himself and/or for his beneficiary

including parents, guardians for minor wards and children etc.

- No fee is required.
- The complaints can be either hand written legibly or typed, but preferably typed. It may be in a local language.
- The complaint can be submitted in person, through agent/lawyers, or by registered post. Documentary support is a must
- The complaint needs to be lodged with in two years from the day of cause of action
- Exception can be made but valid reason to be documented for the same.

Type of Relief under CPA, 1986

- Refund of the charges paid.
- To award compensation for any loss or injury suffered due to the negligence of the opposite party / Nursing home/Hospital/Medical Professional
- To rectify the deficiency in services, and
- To compensate the financial losses occurring to the affected party.

Consumer Disputes Redressal Forum (2,3 &4)

Consumer disputes redressal forum is a three tier system.

I. District Forum: - District Forum is established by the State Government in each district of the State by notification.

II. State Commission: - State Commission is established by the State Government in the State by notification.

III. National Consumer Disputes Redressal Commission is established by the Central Government by notification

District Forum

Composition of District Forum consists of total three members including one lady member. Every member of the District Forum shall hold office for a term of five years or up to the age of sixty-five years, whichever is earlier.

Power of District Forum

- To award compensation to the consumer
- To replace the goods with new goods
- To return to the complainant the price, or as the case may be, the charge paid by complainant

Jurisdiction of the District Forum: Subject to the other provisions of this Act, the District Forum shall have jurisdiction to entertain complaints where the value of the goods or services and the compensation, if any, claimed ''does not exceed rupees twenty lakhs.

Appeal: Any person aggrieved by an order made by the District Forum may prefer an appeal against such order to the State Commission within a period of thirty days from the date of the order, in such form and manner as may be prescribed.

State Commission

Composition of State Commission consists of total three members including one lady member. Every member of the State Commission shall hold office for a term of five years or up to the age of sixty –seven years, whichever is earlier.

Jurisdiction of the State Commission:

- Complaints where the value of the goods or services and compensation, if any, claimed exceeds rupees twenty lakhs but does not exceed rupees one crore.
- Appeals against the orders of any District Forum within the State

Appeals: Any person aggrieved by an order made by the State Commission in exercise of its powers conferred by sub-clause (i) of clause (a) of section 17 may prefer an appeal against such order to the National Commission within a period of thirty days from the date of the order in such form and manner as may be prescribed:

National Commission

Composition of State Commission consists of total five members including one lady member. Every

member of the National Commission shall hold office for a term of five years or up to the age of seventy years, whichever is earlier

Jurisdiction of the National Commission:

- Complaints where the value of the goods or services and compensation, if any, claimed exceeds rupees one crore.
- Appeals against the orders of any State Commission.

Appeal: Any person, aggrieved by an order made by the National Commission in exercise of its powers conferred by sub-clause (i) of clause (a) of section 21, may prefer an appeal against such order of the Hon'ble Supreme Court within a period of thirty days from the date of the order.

The Hon'ble Supreme Court may entertain an appeal after the expiry of the said period of thirty days if it is satisfied that there was sufficient cause for not filing it within that period.

Protection of action taken in good faith: No suit, prosecution or other legal proceedings shall lie against the members of the District Forum, the State Commission or the National Commission or any officer or person acting under the direction of the District Forum, the State Commission or the National Commission for executing any order made by it or in respect of anything which is in good faith done or intended to be done by such member, officer or person under this Act or under any rule or order made thereunder.

Further in the landmark Judgement of The Supreme Court of India in the case of IMA (petitioner) Vs. V. P Shantha & Others (Respondent) (Date of Judgment: 13-11-1995) (5), The Honorable Supreme Court directed that services provided to a patient by a doctor by way of consultation, diagnosis and treatment, both medicinal (conservative) and surgical, would fall within the ambit of 'service' as defined in Section 2(1) (o) of the Consumer Protection Act. Thus CPA includes all medical services offered by the private and government doctors and hospitals. It exempts only those hospitals and the medical practitioners of such hospitals, which offer free service to all patients at all times.

Doctors join medical practice after taking "Hippocratic Oath". Hippocrates is considered to be the father of medicine. The Oath is that "I will use my power to help the sick to the best my ability and judgement; I will abstain from harming or wronging any man by it". It means that doctors should empathise with the suffering of their patients and dedicate to relive their suffering. Any negligence on their part cannot be tolerated. The common men consider the doctor as living god. The expectations of the ailing patients are very high.

Practice of medicine is rendering great service to the society provided due care, sincerity, efficiency and skill are observed by doctors. Medical profession has its own ethical parameters and code of conduct. This profession is rendering a noble service to humanity and has sustained itself on public trust. The present state of medical profession seems to mirror the rot, which seems to have set in to our system. Increased mechanization, technological advancement and commercialization of profession has brought in an element of dehumanization in medical practice. Health care has now come to be perceived as reduced to a business, which determines the patient- doctor relationship.

As we all know and believe, medical profession is devoted to the service of mankind but today decline in the standard of the noble profession as regards empathy, personal touch, proper communication is increasing though various medical technologies have improved. Also the expectations of patients /relatives have gone up and their level of patience has come down. Like western countries in India also more and more patients are restoring to legal remedy against medical negligence. This is due to the drastic change that has occurred in the doctor patient relationship. The golden days of family physician and doctors have ended. In the present scenario the health care has degenerated in to health business. Here the patients are commodities. Budding of new super speciality hospitals are the direct expressions of this as a part of medical practice.

In recent times one has heard of many rackets in our country related to health care. Now we have come across many incidences where doctors are one of the integral parts of inhuman activities and crimes. We are also aware that there are complaints about surgeon doing surgeries which are not really indicated. Improper diagnosis (not based on facts) and unnecessary investigations are another points of complaints. Due to this, unnecessary high expenses are incurred by the unsuspecting patients. Patients are also exploited by the marketing strategies of medical companies. Many drugs banned in western countries or with unproven benefits are sold in India with the prescriptions and supports of doctors, at times in black market at inflated rates.

With all above facts in medical profession, the inclusion of medical profession in the Consumer Protection Act, 1986 seems to be a great work done by the Hon'ble Supreme Court of India .But in recent times many incidences (false allegation on doctors) clearly show that some doctors are being unnecessarily harassed by patient/patient party by making false allegations. Because of this, the perception of doctors regarding consumer protection act has changed. Doctors feel that inclusion of medical practice in Consumer Protection Act has made the medical practice defensive. Also doctors feel that Consumer protection act is curse for medical profession.

In the Law of Torts, professionals such as lawyers, doctors, architects and others are included under negligent act. Any task which is required to be performed with special skill would generally be admitted or undertaken only if the person has the requisite skill. He implicitly assures persons coming to him the skill which he possesses, but he does not assure his client of the result. A surgeon cannot and does not guarantee the result of surgery to be invariably beneficial. The only assurance such a professional can give is that he is in possession of the requisite skill in that surgery and also that he will exercise his skill with reasonable competency. This is all what a person approaching a doctor can expect. Therefore a doctor can be held liable for negligence only for one or both of the above, i.e. skill and competency. Negligence of medical profession necessarily needs a different outlook. So long as a doctor follows a practice acceptable to the medical professional of that day, he cannot be held to be liable. To prosecute a medical professional for negligence under criminal law, it must be shown that the accused did something or failed to do something which no medical professional in his ordinary sense and prudence would have done.

The relationship between doctor and patient are not always equally balanced. The attitude of a patient is poised between trust and uncertainty. Such ambivalence naturally leads to a sense of inferiority in patients. It is therefore the function of medical ethics to ensure that the superiority of the doctor is not abused in any manner. It is a great mistake to think that doctors and hospitals are easy targets for dissatisfied patients. The duties which a doctor owes to the patients are clear. A person who holds himself ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. When doctors advise or prescribe medicines this should be in their mind.

Public awareness of medical negligence in India is growing. Hospital managements are increasingly facing complaints regarding facilities, standards of professional competence and appropriateness of therapeutic and diagnostic methods. Also The Supreme Court of India, in its several decisions, has tried to balance the power structure in doctor-patient relationship. The law does not aim to punish doctors for all their mistakes, only those committed out of proven negligence. Law asks for just and reasonable competence and care. In contributory negligence cases, the law has burdened the doctor only with his share of fault. Consumer protection act is set to benefit the medical professionals by removing quacks from profession and maintain a reasonable degree of standard in the era of cut throat competition and trying to bring the quality of health care. On August 05,2005 a Three Judge Bench of Supreme Court of India in the case of Jacob Mathew v. State of Punjab

and another - 2005 SCCL.COM 456. Criminal Appeal No. 144-145 of 2004 (6) by order quashed prosecution of a medical professional under Section 304-A / 34 IPC and disposed of all the interlocutory applications that doctors should not be held criminally responsible unless there is a prima-facie evidence before the Court in the form of a credible opinion from another competent doctor, preferably a Government doctor in the same field of medicine supporting the charges of rash and negligent act.

In the Landmark case of Dr Kunal Saha vs Dr Sukumar Mukherjee and Others (7), appellant Dr. Kunal Saha had filed a petition before court for establishing Criminal Liability against doctors but Hon'ble Supreme Court quashed the petition stating that this is under the preview of Consumer Protection Act.

The Hon'ble Supreme Court has made it clear that criminal liability cannot be established against doctors in an allegation of medical negligence since medical services are under the preview of Consumer Protection Act. Therefore Consumer Protection Act provides doctors have some relief from criminal liability since we all know the difference of trail under Consumer protection act and Criminal law.

Once our Father of Nation had said "They cannot take away our self-respect if we do not give it to them ". In same way if doctor follows practice acceptable to the medical professional of that day, he needs not to be afraid of a false allegation made against him\her. Therefore, Medical profession needs to practice reasonable degree of skill and knowledge, and must exercise a reasonable degree of care and also update their understanding on consumer protection act and its amendments and their own area of medical practice to be on a legally safe side rather than feeling that consumer protection act is a curse on medical profession. So to conclude this I feel, the consumer protection act of India is neither a curse nor a boon for medical profession. It is helping both the parties by protecting consumer's rights as also doctor's rights and is trying to bring quality in health care.

How to Prevent Consumer Cases in Hospital

At Doctor's Level (3, 4 & 8)

- Always Mention qualifications/experience/ designation on the prescription.
- Mention of scholarships/ membership/ awards which are not qualifications should be avoided.
- Always mention date and time of the consultation.
- Mention age and sex of the patient. In a pediatric prescription weight of the patient must be mentioned.
- Always put your hand on the part that the patient/ attendant say is painful. Apply your stethoscope on him, even if for cosmetic reasons.
- Listen attentively. Look carefully. Ask questions intelligently.
- If, after completing the examination, the patient/ attendant feels that something has been left out or wants further examination, please carry out.
- Always face the patient. Do not stare. Some patients tolerate very little eye contact. Learn to observe out of the corner of your eyes.
- In case you have been distracted/ inattentive during the history taking, ask the patient/ attendant to start all over again. He will never mind it. As far as possible consultations should not be interrupted for non-urgent calls.
- It is always advisable to ask present history of illness, as well as any relevant Past and family history of the patient. If these are not forthcoming, the same should be documented.
- Ask the patient to come back for review if you are not sure about the diagnosis/ treatment or have advised some investigations to reach a diagnosis
- Mention "diagnosis under review" /after provisional diagnosis until the diagnosis is finally settled.
- In complicated cases record precisely history of illness and substantial physical findings about the patient on your prescription.

- If the patient/ attendants are erring on any account (history not reliable, refusing investigations, refusing admission) make a note of it or seek written refusal preferably in local language with proper witness.
- Mention the condition of patient in specific/objective terms. Avoid vague terms.
- Practice Evidence Based Medicine ,e.g. try to demonstrate AFB in the sputum before starting ATT
- Go for tissue diagnosis whenever possible e.g. go for FNAC/ Biopsy
- Don't go by assumptions/speculations/gut feeling.
- Take 2nd or 3rd opinion when in doubt or where patient seems not convinced of your diagnosis
- Avoid empirical treatment to the extent possible, keep the record of the same
- Update yourself by subscribing to Journals/ Conference/Workshops/CME and latest happening in medical field
- Don't prescribe without examining the patient, even if he is a close friend or relative (Telephone advice is an exception- Telephonic consultation should be as limited as possible).
- Never examine a female patient without presence of female nurse/female attendant, especially during genital and breast examinations.
- Don't insist on the patient to tell the history of illness or be examined in presence of others. He has right to privacy and confidentiality.
- Do not permit considerations of religion, nationality, race, party, politics or social standing to intervene between you and your patient.
- Don't smoke while examining a patient, Avoid distractions; mobile phone
- Don't examine a patient when you are sick, exhausted, or under influence of alcohol or any intoxicated substance.
- Don't be overconfident. Don't be perceived as overconfident.
- Don't' prescribe a drug or indulge in a procedure for which you cannot justify its indication.
- Be careful about drug doses and do not under-prescribe.
- Don't prescribe multiple drugs (inability to form a correct diagnosis). Possibilities of drug interactions increase with polypharmacy.
- Don't write instructions e.g. investigations, on a separate slip. Instruction must contain diet, rest, avoidance of alcohol, next visit etc.

Strong Defence for Doctors / Hospitals (4 &8)

- Meticulous documentation; ensure proper maintenance & safety of medical record.
- Audit of Medical Record from time to time.
- No overwriting- cut clearly (so that it remain legible) and rewrite, with signature.
- Informed consent including one for Blood transfusion.
- Explain the procedure, what you aim to do, likely outcome, possible risks & complications, and endorse the same in the prescription/ indoor case sheet, preferably with signature of patient/relatives and in a language which they understand.
- No false claims or promises to the patient/parent's party.
- No loose talk including in operation theatre.
- Explain and document the prognosis in seriously ill patients.
- Keep yourself updated with latest happening in medical profession.
- Seek expert opinion –whenever required or in doubt
- Investigate if needed, practice of evidence based medicine

At Hospital Administrator Level (4&8)

- The role of hospital administrator plays a vital role in hospital management. Availability of Hospital Administrator must be ensured in the hospital. Hospital Administrator should fix a time to meet the general public and grievances and issues of public must be honored.
- Behavior of hospital administrator and hospital staff should be polite, courteous with listening approach.
- Hospital administrator should make a committee for dealing with medical grievances.
- Developing (SOP's- Standard Operating Procedures)) is one of the way to establishing process and system to avoided incidences.
- It is responsibility of hospital administrator to organize exit interview
- A system for collecting feedback ,frequent audit of medical record etc. must be ensured by hospital administrator
- Strengthen systems to strengthen the patient safety in hospital because it is bad system, not the bad people that leads to most errors which otherwise are preventable.
- Strengthening of Medical Records Department in the hospital
- Providing man power to all areas as per norms to provide quality and prompt care to the patients

Total Number of Consumer Complaints (including all sectors) Filed/Disposal since Inception under CPA

S. No.	Name of Agency	Cases filed since Inception	Cases disposed of since Inception	Cases Pending	% of Total Disposal
1	National Commission	87693	76314	11379	87.02%
2	State Commissions	630912	539360	91552	85.49%
3	District Forums	3386762	3123773	262989	92.23%
	TOTAL	**4105367**	**3739447**	**365920**	**91.09%**

Source: *The Department of Consumer Affairs under Ministry of Consumer Affairs, Govt. of India. Updated on 24.3.2014*

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How to Get the Registration for Small Nursing Homes in India

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Introduction

There is no provision of temporary registration of small Nursing homes in India. One can get the Permanent registration of small Nursing homes after filling the required form which one gets from local municipal office. In the municipal office medical official in charge and his department receives the duly filled form and after inspection of the nursing home issue registration of small Nursing homes.

Minimum Standards for Private Hospitals/ Nursing Homes

Up to 30 Bedded Unit Providing Medical / Surgical / Maternity Services

Preamble

This document contains information intended as model standards for planning a nursing home up to 30 beds in respect to functional program, human power, equipment, functional and space requirements. A few essential building services, engineering and environmental requirements have also been covered.

Definitions

A nursing home is envisaged as place where a patient is admitted for overnight medical and nursing care. It is common practice in most nursing homes to provide various disciplines under one roof. This document lists out minimum standards for nursing homes providing medical /surgical/maternity facilities.

Functional Program for a Nursing Home

The basic minimum functions provided by a nursing home should include the following:

1. Emergency First Aid

Emergency first aid is care provided initially to stabilize a victim's condition and to minimize potential for further injury during transport to an appropriate service. At minimum each nursing home shall have provisions for emergency first aid treatment for staff as well as for persons who may be unaware of or unable to immediately reach services in other facilities. This is not only for minor incidents that may require minimal care but also for persons with severe injuries or in grave condition who must receive immediate first aid and assistance for transport to other facilities.

Emergency first aid includes facilities for intubation, venesection, thorough cleaning/dressing of wounds, ligations of bleeding vessels, insertion of intercostal drainage tube, application of Thomas Traction, starting of nasal O2, bladder catheterization, stomach wash, establishing an intravenous line in case of patients in shock, controlling of convulsions, controlling of acute attacks of breathlessness, etc.

Emergency first aid services should be provided to all patients in need of them irrespective of their capacity to pay.

2. General Medicine

All nursing homes providing medical facilities should be able to provide Clinical diagnosis for infectious diseases, diabetes, hypertension, auto-immune disorders, endocrine disorders, neurological disorders, renal disorders, skin diseases, gastro-intestinal disorders, etc. Treatment and follow-up care for a majority of these conditions would also be possible by a physician.

Medical personnel manning such a facility should be able to take a decision regarding cases which require higher medical skills or which may eventually need transfer to a better equipped facility (intensive care,

surgical facility, ventilators, hemodialysis machine, cardiac monitors, etc.) and accordingly transfer such patients at the earliest. In case a patient had been admitted in such a facility for more than 24 - 48 hours, it is expected that the patient will be transferred with a medical attendant *accompanying the patient and all medical records (including X-rays, investigation reports, clinical Advises) will be made available to the next doctor who will be treating the patient. It is also expected that the doctor who had treated the patient initially will keep in touch with the institution to which the patient has been transferred in order to remain aware of the patient's condition.

A nursing home which claims to provide Emergency Cardiology Services should possess intensive care facilities.

3. General Surgery

A general surgical nursing home would be able to provide elective General Surgery for the following: Benign and malignant soft tissue tumours, benign breast disease, carcinoma breast, thyroid surgery benign and malignant conditions of the gastrointestinal tract, benign anal conditions, inguinal hernia, hydrococle, varicose veins, testicular tumours, abscesses, vasectomy, splenectomy, etc.

4. Maternity Facilities

All nursing homes providing maternity facilities should provide basic obstetric facilities and neonatal facilities. All maternity homes should be able to carry out procedures like suction and evacuation, dilatation and curettage, Lower Segment Cesarean Section and Hysterectomy on an emergency basis. Blood transfusion facilities should be available within half to one hour. Also ultrasonography facilities should be available within half to one hour. The functional program of the nursing home should mention nearest availability of neonatal intensive care facilities.

5. Pathology

The type and extent of laboratory facility to be available for a nursing home would depend on the functional program of the nursing home. But provisions shall be made for the following minimum procedures to be performed on site or at a nearby facility.

Blood counts, urinalysis, blood glucose, blood urea and nitrogen, coagulation profile (bleeding time, clotting time, prothrombin time), Blood grouping, typing and cross-matching, serum electrolytes, serum amylase. Provision shall also be included for specimen collection and processing. A separate toilet facility should be provided for the pathology section.

6. Radiology

Equipment and space for the department would have to be planned according to the program functions. In the minimum following X-rays should be possible: X ray chest, abdomen, pelvis, femur and skull. For this an X-ray machine of 300MA capacity is needed. In nursing homes providing emergency surgical facilities and those with more than twenty beds, the X-ray machine should be installed within the nursing home premises. In smaller facilities, it should be possible to have access to such X-ray facilities within one hour. Standard precautions should be taken in the construction of the radiology room. In radiation medicine facilities where procedures like DTPA scan are carried out, separate facilities should be provided for disposal of urine. In case radiotherapy, nuclear medicine facilities are to be provided, guidelines by local statutory bodies should be followed.

7. Health Education

All medical personnel in nursing homes should be aware of all the various national programs for control of various diseases and should integrate with the same. For e.g., on detecting a care of leprosy, information regarding the same must be directed to Medical Officer in-charge of the local PHC/UHC where the survey, education and treatment centre of the National Leprosy Program is situated. Nursing homes should maintain records of all such instances which may be checked by regulating bodies on a periodic basis.

8. Ambulance Services

All nursing homes should have access to ambulance services within half an hour.

9. Medical Records

Records for these also must be maintained as below as per the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002.

Maintenance of medical records

1) Every physician shall maintain the medical records pertaining to his/her indoor patients for a

period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as Appendix 3.

2) If any request is made for medical records either by the patients / authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

3) A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2.

4) Efforts shall be made to computerize medical records for quick retrieval.

5) Maintenance of medical records of all patients attending the nursing home is of utmost importance. The "OPD paper" of a patient attending the OPD should contain the doctor's name and detailed clinical Advise/s, provisional diagnosis and treatment advised. A separate prescription should be written out for the medication that has been advised. The OPD paper should be given to the patient along with X-rays and all investigation reports. Nursing homes may maintain a copy of the OPD paper. All indoor papers should be complete, i.e. clinical Advise/s should be written along with whatever treatment has been given during the admission and reports of investigation carried out. In case of operated patients detailed operation and anesthesia advice should be written. In case of deliveries, labor room Advise/s should be complete. On discharge or on transfer a discharge summary should be given to the patient with all details clearly written down. Also all X-rays and investigation reports should be handed over to the patient. A separate register of all deaths occurring in the nursing home should be maintained. A separate register of all births occurring in the nursing home should be maintained. Duplicate copies must be maintained of all certificates issued by the nursing home.

10. Dietary Facilities [optional]

All maternity homes and all nursing homes with more than 20 beds shall provide dietary facilities for indoor patients.

11. Others

Disciplines like Dentistry, Ophthalmology, ENT, Orthopedics etc. and diagnostic facilities like ultrasonography, C.T. scan, etc. if provided by a nursing home would require design, equipment, space as well as personnel over and above that specified in the document.

Universal biosafety guidelines shall be followed by all nursing homes to protect personnel employed from occupation related diseases. Registration with pollution control board of the state for Bio-Medical waste generation is a must.

Human Power Requirements

Qualifications

Physician: M.D. degree from a university or equivalent from a local recognized body OR diploma from Diplomate of National Board or equivalent from a local recognized body.

Surgeon: M.S. degree from a university OR Diploma from Diplomate of National Board or equivalent from a local recognized body.

Obstetrician and Gynecologist: M.D. degree from a university or equivalent from a local recognized body or diploma from Diplomate of National Board.

Anesthetist: M.D. degree from a university or university or equivalent from a local recognized body OR diploma from Diplomate of National Board.

Neonatologist/Pediatrician: M.D. degree in Pediatrics from university or equivalent from a local recognized body or diploma from Diplomate of National Board.

Duty Medical Officer: MBBS, BAMS should have completed one year of internship. Responsibility regarding clinical decisions, procedures etc. is that of the consultant and not the DMO.

Availability of Personnel

As soon as a patient arrives at a nursing home, (in emergencies) he or she should immediately be seen by a Duty Medical Officer. A nursing home providing MEDICAL facilities should have a physician available on call round the clock. A nursing home providing SURGICAL facilities should have a surgeon and anesthetist available on call. In case Emergency Surgical Facilities are also provided then a surgeon and anesthetist should be available on call round the clock. A nursing home providing MATERNITY facilities should have an Obstetrician and Gynecologist, an anesthetist, a surgeon and a neonatologist available on call round the clock. A nursing home may need an administrator to look after every day running of the nursing home. In nursing homes where consultants are resident, the requirement for D.M.O could be accordingly scaled down.

Minimum requirement of personnel

Duty Medical Officer

- One duty medical officer for every 20 indoor beds or part thereof in every 8 hour shift.
- Two duty medical officers to function as O.T. assistants during routine O.T. hours (8 hrs) and one each for the next two shifts in those facilities providing emergency surgical care and obstetric care (nurses could be trained to perform this function).
- One duty medical officer for the labor ward in every eight hour shift. (Optional: this function may be performed by the O.T. assistant or a trained nurse)

Nursing staff

- One nurse for every 10 beds if on same floor on every eight hour shift and if on different floors then in same proportion on different floors. Here one nurse undergoing training may be posted along with a qualified nurse.
- Two qualified operation theatre nurses for routine surgery. For nursing homes offering maternity facilities and emergency surgical facilities two more operation theatre nurses will be required on shifts. (In practice the number of nurses posted specifically for this area would depend on the patient load there.)
- Four qualified nurses for labor room. One nurse should work in each eight hour shift. They may also function as O.T nurses when required.
- One nurse should be kept available for emergency patients on every eight hour shift.
- During regular OPD hours one more nurse should be kept available for OPD block.

Nursing aids

- One aya or one ward boy for every 8 beds for every eight hour shift.
- One aya for obstetrics and gynecology OPD.
- One ward boy for surgical and medical OPD.
- One aya for labor room.
- One aya or ward boy for O.T. suite
- One sweeper per eight beds for wards in every 8 hour shift.
- One sweeper for operation theatre and Labor ward.

Aya/ward boy/sweeper need to undergo training in nursing care skills like measuring of urine output, assisting in inserting an I.V. line, transferring patients from trolleys to beds, etc.

Paramedical staff

In case a contractual arrangement is being availed of for these functions, then these personnel may be appointed accordingly

- One Pathology technician (optional)
- One Radiology technician (optional)
- One ambulance driver (optional)

Availability of paramedical staff should be adequate to satisfy basic functions as specified in the functional program.

Engineering staff [optional]

- One plumber (To be available on call throughout the day)
- One electrician

- One qualified consultant engineer

Administrative and Ancillary staff [optional]

- Receptionist 2 (on shifts)
- Cashier 1(optional in NHs with low patient turnover this function may be performed by any of the other staff)
- Storekeeper 1
- Stenographers 1 (in NHs with more than 20 beds for maintenance of records)
- Security staff 4 (one per shift)

Minimal Functional and Space Requirements

To facilitate planning and framing of the structural grid a usable space planning module of 14 sq.meter based on basic space unit of 3.5 sq.meter has been stipulated in order to rationalize the requirements for various facilities in the hospital. This space planning module is derived by assuming a planning grid of 1.6 m. Six such grid units i.e. 3.2 x 4.8 m will lead to a carpet area of about 14 sq.meter after deducting the space taken by walls. All floor space requirements recommended for various facilities in respective table of the various sections of general hospital are based on above basic space unit. Fractional variation in floor spaces in actual planning may be ignored. Area requirement for the nursing home is to be derived from carpet area of various functions and services as outlined in the following tables by applying conversion factor (40%) for circulation space. This circulation space will include corridors.

Space requirements have been divided into following categories:-

- Entrance Zone
- Ambulatory Zone
- Diagnostic Zone
- Intermediate Zone
- Critical Zone
- Service Zone

Entrance Zone

1. Entrance hall with Enquiry counter with cash counter and records area (to maintain few OPD records) 28 sq.meter
2. Pharmacy 17.5sq.m

Ambulatory Zone

1. **Medical clinic** (consultation and examination room) 17.5 sq.meter, Waiting area 21 sq.meter
2. **Surgical clinic** (consultation and examination room) 17.5 sq.meter, Waiting area 21 sq. m.
3. **Casualty and emergency care** (optional) 17.5 sq.meter
4. **Treatment and dressing** 21 sq.meter
5. **Injection room** (optional) 17.5 sq.meter
6. **Communication system**

   An efficient communication system within the nursing home is necessary. An intercom system would be the best. If not possible softly ringing alarm bells with lighting up system should be installed connecting wards, nursery units, operation theater, delivery room, labor room to the nursing stations.

7. **Fire-fighting system**

   Efficient fire fighting systems should be installed in every nursing home.

8. **Ventilation requirements for areas affecting patient care in nursing homes**

   There should be good ventilation for comfort as well as for asepsis and odour control in areas in acute care hospitals that directly affect patient care.

9. **Other measures for doctor's safety**

   1. Medical indemnity policy for doctor
   2. Hospital error and omission policy
   3. ISO 9001:2000 accreditation
   4. insurance of hospital premises and equipment

However as required a Hospital has to one point of time has to undergo challenges from any of the Laws of the land to remain on safe practice side of LAW. Wishing the readers all the best.

Medical Negligence

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The last few decades have seen many ups and downs in medical sciences. Some of these are positive changes like scientific and technical advances, increasing longevity, decreasing mortality, morbidity and overall improvement in quality of life. At the same time there are some negative changes such as, decreasing standard of medical education, decreasing values and morality commercialization and corporate culture in management of patients [1]. Bringing the doctors under the ambit of Consumer Protection Act has further marginalized the doctor-patient relationship. The legal cases of medical negligence are rising because of the ease with which cases can be launched in consumer court.

Essentials of medical negligence

Medical negligence is an act of commission or an act of omission which a prudent doctor of average skill, knowledge and experience would not do. The essentials of negligence[2] are: 1) there is duty towards patient; 2) there is deficiency in duty; 3) this directly results in 4) damage which may be physical , mental or financial loss to patient or relatives.

Duty or Care:

As soon as doctor accepts to treat the patient (except in emergency situation) the duty starts. There is no duty if the patient is turned away by the doctor. In this case there is no negligence as there is no acceptance. The idea of negligence and duty are strictly correlative. The duty starts irrespective of financial considerations. The concept of fee is more important in CPA. But a civil/criminal negligence can occur even if patient is treated without any fees. The relationship starts even if the doctor has not directly communicated with the patient (eg. Pathologist, Biochemist, Anesthetist etc.)

Deficiency in care:

According to Justice Denning, it would be a great disservice to community at large; if we impose liabilities on doctors, for each and every thing that happens to go wrong [3]. Standard of care is not a subject of law but a subject of medical judgement. There should be foresee-ability of averting complications in a given situations. The standard of care is also proportional to duty undertaken i.e. a pediatrician is expected to provide a better care as compared to a general practitioner while managing a child. If the doctor commits any deficiency in his duty, he may be liable for his act.

The deficiency in duty must be **"causa causans"** i.e. direct and proximate cause for injury or damage. The cause must be foreseeable and not too remote. eg. If a child of acute gastroenteritis is under treatment and he develops encephalitis, this is not negligence. But if this child develops severe dehydration then it may be negligence.

Res Ipsa Loquitur:

The doctrine of ***res ipsa loquitur*** means "things speak for themselves". The doctor is personally or vicariously liable for the negligent act. In such cases damage is so obvious that there is no need for any proof of negligence. Eg.:

1) operating on wrong eye, limb or patient
2) retained sponges, forceps after surgery
3) doing exchange transfusion on wrong baby etc.

Criminal Negligence:

Sometimes if the act of commissions or omissions are so rash that it results in death or serious injury to the patient then it may amount to criminal negligence. In such cases the situation is much more difficult to tackle as compared to civil negligence.

Theories of Negligence:

The negligence can result either due to an act of commission (which a prudent man shouldn't do) or an act of omission (which a prudent man must do). According to objective theory of negligence [4] there is carelessness in approach towards the patient and the act of commission results in injury to the patient. Following are the some of the examples of acts of

commissions [5]

a) undertaking care beyond one's skill and experience. If a doctor with homeopathy degree practices allopathic medicine, in which he doesn't have basic knowledge is guilty of negligence per se, no further proof is needed. This was held by Supreme court in the case of Poonam Verma Vs. Ashwin Patel and others [6].

b) giving harmful drugs unnecessarily to the patient

c) injuries due to faulty technique eg. Gangrene, necrosis due to leakage of IV fluids, drugs etc. in subcutaneous tissue.

d) Overdoses of drugs, giving wrong drugs etc.

e) Iatrogenic problems.

According to subjective theory, Negligence is mental attitude of undue indifference. The doctor is indifferent to the consequences of his act of omission thus causing damage to the patient. The act of omission can be as follows -

1) failure to attend patient.

2) failure to examine and investigate carefully.

3) failure to obtain proper consent for any procedure or intervention.

4) failure to give standard treatment.

5) failure to take proper precautions while giving injections.

6) failure to give proper instructions.

7) failure to advice hospitalization.

8) abandoning treatment without making alternative arrangements. A doctor should handle only those cases which are within the limit of his knowledge, skill and experience. It is better to refer the case to a proper consultant or a hospital after giving primary treatment. If a doctor has to abandon the treatment under unavoidable circumstances he must make alternative arrangement of a qualified consultant or shift the patient to a properly equipped center.

Contributory Negligence:

Sometimes the unexpected results may not be only due to negligence of the doctor only but also due to negligence of patients or relatives. This is contributory negligence. eg.-

a) not coming for follow-up as per the advice of doctor

b) failure to follow the instructions given by the treating doctor

c) investigations advised by the doctor are not done by the patient

d) patient fails to take advice of a specialist. eg. in case of Acute Abdomen, Head injury etc. The Pediatrician has referred to a Surgeon but patient fails to take surgical consultation.

e) patient leaves the hospital against medical advice

The liability for the damage is suitably divided between doctor, patients and relatives. The burden of proof of contributory negligence on the part of patient is on doctors.

Burden of Proof:

Negligence is difficult to prove. Burden of proof is on patients or relatives (according to law, complainant should prove that the proximate cause of injury is negligence by doctor). But in following cases the onus of proof may be on doctors.

i) if the patient is in OT, ICU, NICU etc. where relatives or attendants have no access.

ii) if the doctor has raised a plea, i.e. suppose a patient of hydro-pneumothorax is admitted. The patient is not taken for surgery and dies of respiratory failure. Doctor pleads that surgery was not done as patient, relatives didn't give consent. In this case doctor has to prove that consent was refused (hence it should always be in writing whether the consent is given or refused).

iii) in cases of ***res ipsa loquitur***

What is not negligence:

In the following situations it is not negligence and hence doctor may not be held liable :-

1) **Difference of opinion:** If there are two accepted schools of thought, any particular method may be adopted by doctor in that patient.

   Bolam's test: In a case Bolam vs. Friern Hospital

management committee in UK the following principles were derived -

If there are two accepted schools of thought, for any treatment, doctor may use any one of them. If some complications occur due to particular method doctor can't be held responsible only on the ground that why he didn't use the other method. [7]

2) **Wrong diagnosis in-spite of diligence:** Sometimes it is very difficult to differentiate between some of the common and similar presentations of diseases like partially treated pyogenic meningitis, tubercular meningitis, encephalitis. In such cases if doctor has taken all the care but still complications occur due to improper diagnosis, then this is not negligence.

3) **Accidents:** Sometimes some accident may occur during hospital stay like; breaking of needle, instruments not working etc. It is not negligence if such accidents are detected, attended and managed within reasonable time.

4) **Unexpected results:** According to Sir Williams Osler (an USA Physician) medicine is a "Science of uncertainty and art of probability". All persons in community do not acquire all diseases. There is always a probability and chance of acquiring a disease. Some acquire the disease while others not, in-spite of being exposed in equal amount. Every individual has different body response not only to disease but also to treatment. Hence there is uncertainty in every case. Hence we talk of "most probable diagnosis" and "most probable outcome" of disease. A doctor can't be held negligent only because there was unexpected outcome.

Defenses in negligence:-

Whenever there is allegation of negligence, the following defenses may be pleaded by the doctor:

a) **Actual Denial:** If a doctor is very confident that there is no negligence on his part , the best way is to deny that the injury is due to negligence.

b) **Contributory Negligence** on part of patient, relatives shall be helpful in minimizing the severity of the doctor's negligence. Eg.

1) Patient was instructed to come for regular follow-up but he doesn't turn up.

2) Patient was instructed to remain nil orally but the patient was given orally.

c) **Delegation of Duties** to a qualified assistant, partner, laboratory attendant or nursing staff may be one of the defenses. In such cases the responsibility is of the person to whom duty was delegated. But if a consultant delegates his responsibility to his junior with the knowledge that junior was incapable of performing his duties properly, this is negligence on part of consultant. This was held by Supreme court in the landmark decision in the case of Spring Meadows Hospital Vs. Harjot Ahluwalia thro' K.S. Ahluwalia [6]. The doctor shall be liable for the act of their staff if they are unqualified. This is vicarious liability. But if the qualified staff makes the mistake then the doctor may not be held directly responsible.

d) Inherent Risk: There is "assumption of risk " whenever treatment is started. This is based on principle of "Volenti non fit injuria" i.e. no person can ask for any action if he has voluntarily consented for it. eg. Radiation burns may result even during proper radiation therapy. This is not negligence. But patient has a right to sue if burns result from overexposure.

e) Emergency Situation: Cardio-respiratory arrest is an emergency situation. Sometimes fracture ribs can occur during cardio-pulmonary resuscitation. A doctor can't be held negligent for causing fracture rib in such situation.

f) Known Complications: Some drugs or procedures have known complications. eg. Anaphylaxis after Penicillin injections is a known complication. A doctor cannot be held responsible if proper sensitivity test was done and all measures for management of anaphylaxis were readily available in the hospital.

g) Unexpected Results: Sometimes unexpected results occur in-spite of proper diagnosis and adequate treatment. A doctor cannot be held negligent in such cases. eg. A pre-term or small for date baby may develop cerebral palsy or mental retardation in-spite of adequate and proper care. A doctor shouldn't be held negligent for this

outcome.

h) **Difference of Opinion:** There may be difference of opinion amongst doctors while treating a case. This is not negligence. These principle were derived in "BOLAM'S TEST".

i) **Limitation Period:** If a particular case is filed beyond the period of limitation (according to Civil Law 3 years), this defense could be forwarded by the defendant. While managing a child the limitation period may extend till he becomes major (Sec. 6 of Limitations Act 1963) and is able to take his own decisions. So in case of neonate the limitation period may extend as long as 21 years of his age (age of majority 18 yrs. plus period of limitation 3 years).

j) **Counter Suits:** Counter suits by doctors against the patients may be helpful in minimizing cases of negligence.

k) **"RES JUDICATA"** means "the thing has been decided". This means that once the case is completed between two parties, it cannot be tried again between the same parties. eg. If a doctor sues a patient for non payment of bill, the patient doesn't plead negligence on part of the doctor. The patient cannot subsequently sue the doctor for negligence after the completion of the case.

Precautions against negligence :

The cases of negligence against doctors are rising. Members of medical profession are constantly under the spotlight of media scrutiny though they enjoy a significant degree of cultural and social authority in the press(8). It is said that "An ounce of prevention is better than a pound of cure". So it is better that we take precautions to prevent the cases of negligence rather than fighting them out in the court of law. The following steps may be helpful in avoiding cases of negligence :-

a) **Attend and treat patients** with reasonable care and skill. Second opinion may be taken whenever required (specially in complicated and critical patients). Advice proper investigations related to the case. While managing a case give guarded prognosis. "Guarantee for care and not cure" while treating a case. Keep the hospital instruments and equipment's in proper and working condition. Instruments must be properly sterilized. Most malpractice suits claim negligence. The claims usually include failure/ delay in diagnosis, negligent treatment, failure to obtain expert opinion, failure to obtain informed consent and negligence during the procedure [9].

b) **Record Keeping:** Proper record must be maintained including history, examination and investigation reports. Treatment adopted, consent for various procedures (including refusals) and any expert opinion if advised shall be recorded in writing. A well maintained record can be a friend of the doctor in an hour of crisis. Don't try to manipulate the records [10].

c) **Staff and Partners** including assistants, subordinates, locum etc. should be selected carefully. They shouldn't only be qualified but their behavior towards the patient should also be good and compassionate. Communication skill with patient and relatives should be good. It is the responsibility of the hospital management to provide proper equipment's, qualified, competent, trained paramedical and nursing staff. If proper and adequate facilities are not available, a timely referral to well equipped center is a desirable alternative.

d) **Don't Criticize Colleagues:** Criticizing our own colleagues is one of the major cause of increasing litigation against doctors. Before making any comment we must verify the actual facts and situation in the particular case. It has been observed that majority of cases in CPA are because of the instigation and criticism by some of our own disgruntled colleagues.

e) **Update your knowledge:** A doctor should try to keep abreast with latest developments as far as possible in his field. Law doesn't expect to know each and every detailed advances, but one must know the things expected of an average prudent man.

f) **Inform regarding hazards:** The patient and relatives should always be informed regarding complications or adverse reactions of drugs, procedures. As far as possible the consent should be an informed consent (preferably in presence of witnesses). Informed consent may be helpful in cases of negligence, but it does not give absolute

immunity. While giving drugs like Penicillin, Xylocaine etc. a proper sensitivity test must be done. If complications occur measures for emergency treatment must be readily available. Injection vials should be preserved for about 24 hours. In-spite of all the precautions if reaction occurs, it is an accident and not negligence.

g) **Insurance:** Professional indemnity cover may be helpful whenever there is a litigation in the court. It may not be helpful in minimizing the damage to the reputation of the practitioners, but it may help as far as financial liabilities are concerned. The insurance companies may also help by providing services of Advocates and legal experts as the companies are themselves parties to such litigation's. The disadvantage of insurance is that ;- 1) if the patients or relatives know that the doctor is insured then they may be encouraged to go in for the litigation. 2) Many times even the insurance companies are willing for the out of the court settlement which is cheaper and of "least resistance" to them rather than fighting out the case.

h) **Counter Compensation suits:** The time is not far away when doctors will need to file counter suits against patients. Such trends have started in western countries and it has been observed that this has resulted in decreased incidences of negligence suits against doctors.

Role of medical councils:

The Medical Council of India is concerned with standard of medical education, while the State Medical Councils deal with the complaints of negligence against doctors. It was expected that the councils will be effective in providing cheap and quick justice. The councils have power to punish the doctors by giving warnings, suspending their registrations (temporarily or permanently) but they can't order compensation to the patient. It is desirable that Medical Council Act be updated so as to give more powers to decide patient's complaints.

Now a days the doctor-patient relationship is under constant strain. The doctors must be aware of the pros and cons of day-to-day medical practice. We must communicate and behave properly with the patient and their relatives. Records must be properly maintained. The best way is to avoid legal cases by having grievance redressal forum and medico-legal cells, preferably in the hospital premises itself.

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Legal Issues in Medical Tourism

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Medical tourism is "Traveling by patients/medical service recipients from one institution, jurisdiction or country to another institution, jurisdiction or country where they can obtain, without legal hindrances, the kind of medical procedures and innovative treatments they desire; mostly, at a lower cost but, in some cases, at a higher cost, for better results". There are at least 50 countries offering this kind of services internationally. Popular medical travel worldwide destinations include: India, Mexico, Brazil, Singapur, Thailand, Argentina, Brunei, Cuba, Colombia, Costa Rica, Hong Kong, Hungary, Jordan, Lithuania, Malaysia, The Philippines, South Africa and recently, Saudi Arabia, UAE, Tunisia and New Zealand.

Often, the medical tourist tries to use this opportunity to also enjoy the holiday and sightseeing in the country they plan to visit. Thus, he is doubly benefited. Medical tourism is comprised of three basic aspects: hospital/health services, hotels and travel/leisure. Thus, with attractive policies and/or the correct marketing strategies, this emerging industry can have significant opportunity for economic growth and infrastructure development for participating nations.

Evolution of Medical Tourism

The concept of medical tourism is not a new phenomenon. Since ancient times people have travelled to other countries/destinations to seek medical treatments for various reasons. Even in ancient times, people traveled to other countries for health related purposes. The ancient Greeks and Egyptians travelled to health resorts in the Mediterranean for purification and spiritual healing. The first recorded case of medical tourism described Greek pilgrims who traveled from the Mediterranean Sea to Epidaurus, a small territory in the Sardonic Gulf, known as sanctuary of Asclepius, the healing god. Since the 1500s India has enjoyed a rich history of providing yoga instruction as well as Ayurveda healing to patients from around the world. Roman British patients traveled to a reservoir around hot springs at Bath for healing and rejuvenation. At the end of 18th century Europeans traveled to spas in Germany and the Nile in Africa, in hope that they would obtain relief from their disabling conditions, such as tuberculosis, gouts, bronchitis, or liver diseases; especially in Europe, well-to-do people, over the years, have traveled to spas to "take the waters" for various cures. In 20th century, patients began traveling in search of alternative forms of treatment e.g. Hoxsey Clinic, Tijuana, Mexico. Umrungrad International Hospital and Bangkok International Hospital, Asia. In 21st century, the U.S. internationally promoted centers of excellence: world-renowned Cleveland Clinic, Mayo Clinic, University of Pittsburgh Transplant Center and M.D.

Anderson Cancer Center; thereby attracting "cash paying" patients from around the world.It is only in recent times that less developed countries have developed expertise and facilities for treatment of complicated medical conditions to a level comparable to that of developed countries of the west. These countries have attractive policies in place and have implemented unique marketing strategies that encourage the medical tourism business. This industry has demonstrated significant impact on this nation's economic health.

There are some specialty markets within medical tourism that are also emerging as significant businesses. Health tourism is travel in a recuperative climate with natural therapeutic resources. The health tourism business is more specifically known for offering yoga, massage, traditional ayurvedic medicine and spa resorts.

Fertility tourism is also quite common. The main reasons for fertility tourism are legal regulation in the home country and lower price. In-vitro fertilization and donor insemination are major procedures involved. Other legal regulations may also contribute. For example, couples from the People's Republic of China seek fertility treatments abroad to circumvent the one-child policy. Many countries have no restriction on how many embryos may be transferred. India is a main destination for surrogacy. Indian surrogates have been increasingly popular with fertile couples in industrialized nations because of the relatively low cost. Indian clinics are at the same time

becoming more competitive, not just in the pricing, but in the hiring and retention of Indian females as surrogates. Clinics charge patients between $10,000 and $28,000 for the complete package, including fertilization, the surrogate's fee, and delivery of the baby at a hospital. Including the costs of flight tickets, medical procedures and hotels, it comes to roughly a third of the price compared with going through the procedure in the UK. Surrogacy in India is of low cost and the laws are flexible. In 2008, the Supreme Court of India in the Manji's case (Japanese Baby) has held that commercial surrogacy is permitted in India. That has again increased the international confidence in going in for surrogacy in India.

Russian Federation legislation makes Russia attractive for "reproductive tourists" looking for techniques not available in their countries. Intended parents come there for oocyte donation, because of advanced age or marital status (single women and single men) and when surrogacy is considered. Gestational surrogacy, even commercial is absolutely legal in Russia, being available for practically all adults willing to be parents.

The United States is sought as a location for surrogate mothers by couples seeking Green Card in that country; since the resulting child can get birthright citizenship in the United States, and can thereby apply for Green Cards for the parents when turning 21 years of age.

Suicide tourism is a very small branch of medical tourism yet its presence is still notable. This practice, much more so than the others, is tightly structured by policy.

India's Medical Tourism

India is amongst one of the top medical tourism destinations. India's medical tourism sector is expected to experience an annual growth rate of 30%, making it a Rs. 9,500-crore industry by 2015. Advantages for medical tourists include widespread use of English, lesser costs, the availability of latest medical technologies and a growing compliance on international quality standards. However , poor infrastructure is a big hindrance in the growth of medical tourism but the Indian government is trying to deal with it .According to most estimates claim treatment packages in India cost around a tenth of the price of comparable treatment in America or Britain. The most popular treatments sought in India by medical tourists are alternative medicine, bone-marrow transplant, cardiac bypass, eye surgery and hip replacement.

Hospital groups like Apollo Hospitals and Fortis Healthcare have increased their presence in international market for medical tourism. The south Indian city of Chennai has been declared India's Health Capital, as it nets in 45% of health tourists from abroad and 30-40% of domestic health tourists.

Ministry of Tourism India (MoT) is planning to extend its Market Development Assistance (MDA) scheme to cover Joint Commission International (JCI) and National Accreditation Board of Hospitals (NABH) certified hospitals. A policy announcement of this effect is likely soon.

Risks In Medical Tourism

Medical tourism carries the following risks -

Communication may be a problem. Receiving care at a facility where you do not speak the language fluently increases the chance that misunderstandings will arise about the care.

South eastern countries such as India, Malaysia, or Thailand may impose upon the tourist from western hemisphere some infections not experienced by them in their host country, and the tourists may not have enough immunity in their body system to deal with such infections, for example gastrointestinal diseases e.g. Hepatitis A, amoebic dysentery, paratyphoid, mosquito-transmitted diseases, influenza, and tuberculosis. These can be contracted by tourists, resulting in complicated prognosis while they are availing of the treatment. However, at the same time, doctors in south eastern countries may be more open to recognizing and diagnosing these infections.

There is also concern that medical tourists are at risk of exposure to blood-borne infection due to inadequate blood collection, screening and storage protocols in destination countries. Individuals travelling for organ transplantation in particular may experience higher rates of severe infectious complications because of inadequate screening protocols abroad.

There is also concern that medical tourists may transmit infections to their home countries, an example is the spread of New Delhi metallo-beta-lactamase 1 (NDM 1) to the home countries of patients who had been treated abroad.

The quality of medical treatment and post-operative care may vary between the developing and the

developed world; between the hospitals and countries , and may be different from US or European standards. Differences in healthcare provider standards around the world have been recognized by the World Health Organization, and in 2004 it launched the World Alliance for Patient Safety. This body assists hospitals and government around the world in setting patient safety policy and practices that can become particularly relevant when providing medical tourism services.

Post operatively or post treatment, traveling long distances can increase the risk of complications. Long distance flights and decreased mobility with cramped seating in economy class are known risk factors for developing venous thrombosis or pulmonary embolus, this phenomenon is also known as "economy class syndrome".

The quality of medication is also an issue .Medicines may be counterfeit or of poor quality in some countries where corruption is rampant and regulations are lax.

There is issue of post treatment complications, researchers examining outbound medical tourism from Oman found that 15% of 45 surveyed medical tourists experienced complications following treatment abroad, while a survey of the British Association of Plastic, Reconstructive and Aesthetic Surgery found that 37% of members had seen patients with complications resulting from medical tourism.

Legal Issues In Medical Tourism

Because medical tourism is still in evolving stage there are many issues not addressed adequately so far; health facilities of a country may lack an adequate complaints policy to deal appropriately and fairly with complaints made by dissatisfied patients.

The limited& uncertain nature of litigation cover in developing countries is one reason for slow uptake of medical tourism there. While some countries currently presenting themselves as attractive medical tourism destinations provide some form of legal remedies for medical malpractice, these legal avenues may be insufficient to appeal to the medical tourist. Should problems arise, patients might not be covered by adequate personal insurance or might be unable to seek compensation via malpractice lawsuits.

Hospitals and/or doctors in some countries may be unable to pay the financial damages awarded by a court to a patient who has sued them, owing to the hospital and/or the doctor not possessing appropriate insurance cover and/or medical indemnity. However new insurance products are available that protect the patient should an alleged medical malpractice occur overseas.

There are other issues; for example, the illegal purchase of organs and tissues for transplantation has been alleged in countries such as India and China. If a racket is caught by law enforcement agencies what is the liability of the medical tourists who have received organ donation from service provider facility which has been involved ?

Ethical issues in Medical Tourism

Medical tourism creates some ethical issues .It is often debated that that medical tourism for rich people only will lead to a divide between haves and have nots. In Thailand, in 2008 it was observed that doctors have become so preoccupied with foreigners that Thai patients are being neglected. Same issue stands for India .Is the industry's tremendous growth a positive development for the poor Indians that do not directly benefit from it? When thousands of Indians die every year from preventable illnesses, should the Indian government create policies and use public funds to assist private hospitals that respond predominantly to the demands of the rich and foreign? Is medical tourism healing the world but hurting a nation? A concept of cosmopolitan nationalism must guide solutions to these dilemmas. Medical tourism in India will only truly become an ethical success only if basic health is provided to all.

A striking example of "health for rich" India is a leading hospital in New Delhi. The hospital was built in 1996 on 15 acres donated by the Delhi government. The government invested millions in the construction of the hospital and contributed more money as equity capital. It also provided tax and duty waivers on import of equipment. All of this assistance was offered with the agreement that the hospital would reserve one-third of its beds for the treatment of poor patients at no cost. In 1999-2000, only 2% patients in this hospital were treated free and most of these were relatives of staff, bureaucrats and politicians.

Centers offering stem cell treatments are often criticized on grounds of fraud, blatant lack of scientific rationale and patient safety. However, when pioneering advanced technologies, such as providing 'unproven' therapies to patients outside of regular

clinical trials, it is often challenging to differentiate between acceptable medical innovation and unacceptable patient exploitation.

Presently there are no systematic legal frameworks for medical tourism. Hence there are different regulations in different countries and in some countries the legal cover is very deficient. Ironically ,the countries which are taking more risks with health care liability are attracting more medical tourists. Other countries, like the United States, have not been able to benefit as greatly from medical tourism because of increased legal liability and policy.

Reproductive (Abortions and in vitro fertilization) and suicide tourism raise ethical issues. With reproductive tourism, often consumers travel to another jurisdiction to receive a service that cannot be provided at home or is much costlier. Abortions and decisions surrounding in vitro fertilization can be two specific practices that can have ethical objections. This is true for suicide tourism as well. There are issues surrounding the rights of the individual accompanying the consumer. Some countries view this as assistance, which often is prohibited.

In reproductive and suicide tourism, a consumer's rights are important issues. Consumers must consider their rights, and they may seek treatment in alternative locations if a different area's policies better serve their rights. This could be true for practices or procedures such as abortions, in vitro fertilization, as well as euthanasia. Thus, consumer's rights may play a part in decisions made for the medical tourism product.

The illegal purchase of organs and tissues for transplantation had been alleged in countries such as India and China prior to 2007.

International healthcare accreditation

Standards are important when it comes to health care; there are parallel issues around medical tourism, international healthcare accreditation, evidence-based medicine and quality assurance.

In USA, the best known accreditation group is the Joint Commission International (JCI). They inspect and accredit medical tourism facilities outside of the USA. They are veritable source for American medical tourists. Many international medical tourism facilities seek JCI accreditation to attract American patients.

In the UK and Hong Kong, the Trent International Accreditation Scheme is operational in this field. The different international healthcare accreditation schemes vary in quality, size, cost, intent and the skill and intensity of their marketing. They also vary in terms of cost to hospitals and healthcare institutions making use of them.

Increasingly, some hospitals are looking towards dual international accreditation, perhaps having both JCI to cover potential US clientele and Trent for potential British and European clientele.

Other relevant organizations include:

- The Society for International Healthcare Accreditation (SOFIHA)
- Health Care Tourism International, the first US-based non-profit organization which accredits the non-clinical aspects of health tourism, such as language issues, business practices, and false or misleading advertising prevention.
- The United Kingdom Accreditation Forum (UKAF)
- The International Medical Travel Association, (IMTA, based in Singapore)
- Medical Tourism Association, is the second nonprofit association in the industry which focuses on transparency in quality and pricing

Conclusion

- Medical tourism is a relatively new kind of medical business which is becoming increasingly more popular worldwide.
- The business is bound to increase exponentially in future.
- Medical tourism helps increase a country's prosperity in many ways.
- Medical tourism is a very competitive field and the competition is likely to increase in future.
- India is also having an emerging medical tourism industry but at present the volume of business coming to India is less compared to some other countries.
- If India is to really benefit from this phenomenon it will have to make its medical and tourist infrastructure and marketing better, cost effective, time saving and policies more tourists friendly.
- It is those countries that can continually analyze in this field and adapt better policies that will prosper in the emerging medical tourism industry.

UPT-How Much Reliable?

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Urine pregnancy test is the routine simple investigation done by the Gynecologists, Pathologists and many a times by General practitioners when a female patient in the reproductive age misses her menses. Due to the mass awareness campaign initiated by the Indian government, sometimes patients get it done on their own and approach consultant. No doubt the test is useful in very early pregnancy when internal examination alone may not prove conclusive. But the test lacks in sensitivity as well as in specificity because of many factors and therefore it cannot be relied upon completely. It can mislead the practitioner and may prove disastrous as far as medico-legal aspect is concerned. Following case law will highlight this.

Bakul Khandelwal Vs. Dr.Girish Goyal and another II(2007)CPJ 94

Facts :

1) A practicing advocate of Deharadun went to District Hospital for women run by the government on 14/11/1996 for check up.
2) Urine pregnancy test was advised.
3) Dr. Girish Goyal's pathology lab. did the test on the same day and the report was pregnancy test positive.
4) On the basis of that report the government medical officer advised complete rest and gave some medicines and injections.
5) On 15/12/1996 patient got lower abdominal pain and therefore consulted Dr. Amrit Grover who advised pelvic ultrasound.
6) The ultrasound was done on 20/12/1996. The report revealed normal size uterus and there is no pregnancy.

It was alleged that on the basis of pregnancy test positive report given by Dr. Girish Goyal, patient had to take bed rest and spend money on medicines and injections. Therefore compensation of Rs. 26,300/- was claimed.

Defense:

It was defended that since Human Chorionic Gonadotrophin hormone was detected in urine, positive pregnancy test report was given.

Expert Witness:

The Chief Medical Superintendent of District Women's' Hospital as an expert witness opined that ,

1. Urine pregnancy test by Eliza technique though reliable is not 100% correct.
2. If the test was positive on 14/11/1996 and afterwards abortion occurs, the USG conducted on 20/12/1996 would give negative result.

District Forum:

Judgment was delivered in favor of doctor saying that there was no negligence.

Appeal by patient:

Findings of State Commission :

1. If the UPT was positive on 14/11/1996 and if abortion occurred subsequently , as per Expert witness, USG report on 20/12/1996 would be negative.
2. Abortion might have occurred after 14/11/1996 i.e. after UPT.
3. No negligence proved.

Decision of Uttaranchal State Consumer Dispute Redressal Commission,Dehradun :

1) Dr. not negligent.
2) Complaint dismissed.

Message:

UPT is not 100% correct.

False-positive or False-negative reactions are seen in the case of abortions and other diseases.

Conclusion:

Miscommunication and misconception give rise to such case which had no substantial ground. It also tells us that one should not solely rely upon UPT results and final diagnosis should be given only after confirmation by sonography.

Readers Ask, Experts Answer

Answers by

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Q1. If I admit a child with some ailment and at night baby turns serious and I am not informed and by the time I get to know baby is critical and finally dies. Now ...

1) what is my liability in this case?

Answer: Under the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002.

2.1 Obligations to the Sick: 2.1.1 Though a physician is not bound to treat each and every person asking his services, he should not only be ever ready to respond to the calls of the sick and the injured, but should be mindful of the high character of his mission and the responsibility he discharges in the course of his professional duties. In his treatment, he should never forget that the health and the lives of those entrusted to his care depend on his skill and attention. A physician should endeavour to add to the comfort of the sick by making his visits at the hour indicated to the patients. In Kamlesh v Dr. Abhijit 2000 (3) CPR 498, a patient with respiratory problem was advised admission, consultant also gave similar opinion and patient was shifted to a hospital where he ultimately died. It was accused that the doctor was not there at the time of death and hence negligent. It was opined that one can't expect that the doctor should always remain present by the bedside.

The standard of care is also proportionate to the expertise of the doctor and the extent of duty undertaken. A Pediatrician is more liable for a case of negligence while managing a child as compared to a general practitioner. A physician advising a patient to seek service of another physician is acceptable; however, in case of emergency a physician must treat the patient. No physician shall arbitrarily refuse treatment to a patient. However for good reason, when a patient is suffering from an ailment which is not within the range of experience of the treating physician, the physician may refuse treatment and refer the patient to another physician.

2) what is hospital's liability?

Answer: Liability is as per vicarious liability rule of law. A doctor can delegate his duties to a qualified and competent junior, assistant, partner, nursing staff or laboratory assistant. This defense was accepted in a case, C.A.R.S. v H.T. Hospital II (1999) CPJ 208 where it was alleged that the child died because consultant didn't examine and attend the patient. In this case negligence was not held on the ground that the junior to whom the duty was delegated was himself a qualified pediatrician and he had regularly attended the patient. In such situation it is the responsibility of the person to whom the duty was delegated. The person delegating the duty can't be held negligent if something unto-wards happened. But if the staff to which the duty is delegated is unqualified or incompetent, then it is the liability of the doctor delegating such duty. An admitted child requiring regular suction was left under the care of an unqualified person. After the death of the child it was alleged that there was nonattendance and wrong diagnosis. In this case PK Sony v Dr. RR Shah II (1998) CPJ 627, there was no documentary evidence that doctor regularly attended the patient, hence negligence was held and damages were allowed. This is vicarious liability. If the qualified staff makes a mistake then the doctor may not be held directly responsible. This landmark judgment was given by hon. Supreme Court in Spring Meadows hospital Vs. Harjot Ahluwalia through K. S. Ahluwalia.

Q 2. If the parents want case papers and CCTV footage are you bound to give it?

Answer: Under the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002.

1.3 Maintenance of medical records:

1.3.1 Every physician shall maintain the medical records pertaining to his/her indoor patients for a

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Helpful Measures for Prevention and Strong Defense of Lawsuits

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It is now well known that medical services are covered under CPA and litigation against doctors has become a bitter reality as well as a common occurrence. Here are some suggestions for few safeguards to primarily reduce the risk for filing of lawsuits yet provide a strong defense in case of unavoidable litigation.

1. Awareness of potential areas for litigation in medical field.
2. Self and professional auditing with regular updating of medical knowledge.
3. Clear concepts of legal terms like medical negligence, medical malpractice, vicarious responsibility, legal notice etc through updates on legal issues via books, journals, workshops and seminars.

1. Medical indemnity insurance is a desirable and potentially useful investment (reassuring, though hoped never to be utilized!).
2. Treat every patient as a potential litigant and take no shortcuts while following protocols.
3. Genuine indication for any procedure must be documented with supporting investigations.
4. Proper patient selection with counseling of other available options for management with complete documentation of discussion and written, informed consent, preferably in patient's or close relative's own handwriting.
5. A common format of indoor case sheets, operative notes, consent forms in English as well as local language is desirable and helpful in a given locality, city or state.
6. Appropriate investigations especially before procedures as indicated; minimum being hemoglobin, blood grouping, blood sugar, serum creatinine, blood urea, urine routine microscopy, ultrasound, ECG, Chest X ray, written physician opinion of fitness for surgery. Additional special investigations like CT scan, MRI, EEG, nerve conduction studies etc can be requested as needed.
7. Honest appraisal of one's capabilities as well as limitations for performing a procedure as well as for managing complications if they arise.
8. Adequate training.
9. Managing patient in a duly registered, well-equipped hospital with a fully equipped operation theatre.
10. Maintaining documents and registers as required under the various laws governing medical practice such as Nursing Home Act, MTP Act, PCPNDT Act, etc.
11. Provide standard medical care as per existing guidelines.
12. Avoid cross-pathy practice and prescribing alternative medicine drugs.
13. Avoiding cross-specialty practice unless facing an emergency with non-availability of appropriate consultant.
14. Involving other specialty surgeon as anticipated or required intra-operatively.
15. Requesting senior consultant help in a difficult case.
16. Timely referral if required, with proper referral note and accompanying medical person.
17. Availability of oxygen and emergency medications in hospital and OT.
18. Ensuring availability of emergency drugs in OT of not less than 3months from expiry.
19. Trained staff in OT and post-operative ward since vicarious responsibility for errors by supporting staff lies on doctor and hospital.
20. Adopting checklists prior to starting a blood transfusion or any surgical procedure.
21. Confirming correct patient, consent and investigations prior to starting the procedure.

22. Pre-anesthetic check up by a qualified and experienced anesthetist is preferable for elective cases.
23. Timely documentation of intra-operative findings and management by surgeon as well as anesthetist with no contradictions in notes.
24. In case of complication, documentation of appropriate management and involvement of second opinion and surgical assistance by another doctor.
25. Preserve the empty vials, ampoules, injectable medications in case of a mishap especially in OT to avoid allegation of a cover-up.
26. 3 R's for dealing with any mishap situation are: RECOGNIZE, RESPOND, RESOLVE. It means the doctor patient relationship is preserved through clear, concise, communication regarding treatment related injury. When adverse outcome occurs doctor must discuss this with the patient and family addressing their concerns and questions in a frank and open manner. Early and clear communication can reduce litigation exposure.
27. Avoid verbal instructions for medications to reduce risk for error.
28. Adequate monitoring and documented visits by consultant preferably in own handwriting.
29. Discharge summary should contain instructions for patient preferably in vernacular language. Retain a copy of discharge card in hospital record.
30. Follow up visits should also be documented.
31. Taking opinion of a medico-legal consultant before replying to a legal notice and never ignoring a legal notice.
32. Preserving indoor case records for proper length of time as required under law and publishing a public notice in local newspaper prior to destruction of older records.
33. Developing risk management strategies – it is a prospective process which identifies factors prompting legal action and attempts to improve the medical system to prevent future losses. Risk management involves the participation of health care providers of all types, attorneys, various technicians, health insurance providers, hospital administrators and many others. When a potential risk is identified, there are several possible resolutions. These might include the development of education programs, a review of the performance of clinicians, the purchase of new equipment or changes in existing protocols and practice guidelines.

Readers Ask, ...

period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as Appendix 3.

1.3.2. If any request is made for medical records either by the patients / authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

The hospital or the individual doctor is the legal custodian of the records. The original record is the property of the hospital. The copy of the record shall be given to the patients or relatives specially when asked for. National Commission in, T Ramarao v. Vijay Hospital I (2008) CPJ 170 (NC) held that non-production of documents will lead to draw adverse inference. The National Commission had following observations in, PS Grewal v. CS Chawla I (2007) CPJ 125 (NC); it is high time for doctors to write correct notes in operation record / discharge summary and these documents to be made available to patient as a matter of right. Not maintaining proper written record of the treatment given was considered as deficiency in service and a cost of Rs. Ten thousand were allotted to the complainant.

1.3.3 A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb-mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2.

1.3.4 Efforts shall be made to computerize medical records for quick retrieve.

Medicolegal News

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Referring a patient is not abandonment or negligence: NCDRC

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New Delhi: A doctor cannot be charged against patient abandonment or negligence if he or she refers the patient to another physician, according to a recent judgment by the National Consumer Disputes Redressal Commission (NCDRC).

"Referring a patient is not a case of abandonment or negligence. Although referrals generally improve the quality and care to the patients, it sometimes happens that a patient claims injury while under treatment. A doctor cannot be charged against patient abandonment if he or she refers the patient to another physician. Healthcare providers are bound by a code of ethics that states that a professional, who begins treating a patient's illness willingly, should complete the treatment to the best of his or her ability. Healthcare professionals should not stop treatment, unless they are not able to treat the patient correctly or if they disagree with the patient about the way in which treatment is being administered," said the NCDRC.

The case relates to Babu Lal Gupta (57), a businessman dealing with electric bulbs and tubes, who was suffering from diabetes and controlled it through medication without complications. He took some laser treatment in February 1999 and his eyesight was working quite well. Thereafter, in September 2000, he was treated at Dr Shroff's Charity Eye Hospital and he underwent operation on the left eye — fill in laser photocoagulation by indirect laser ophthalmoscope. The hospital then referred him for the further evaluation to Dr Lingam Gopal, consultant vitreoretinal services, Medical Research Foundation, Chennai.

In November 2000, the patient was examined at Medical Research Foundation, Chennai and was advised surgical intervention in the right eye. For the left eye, a laser treatment was decided for. Accordingly, Gupta was advised to be on waitlist due to a backlog of appointments for the surgery. To avoid delay and any unexpected complications during the waiting period, the patient was advised to seek other medical facility, elsewhere. He went to Navjyoti Eye Centre in Delhi for further management.

Upon examination, Navjyoti doctors found that Gupta could only perceive light but not hand movements or finger counting. They operated upon both the eyes. After some time, Gupta experienced deterioration in vision. He underwent two more surgeries at Navjyoti. As his condition did not improve, doctors referred him to the Retina Foundation and Eye Research Centre in Ahmedabad, and then to Sankara Nethralaya, which gave the same advice. Navjyoti doctors then operated upon Gupta for glaucoma for intra-ocular pressure. As his condition did not improve, Gupta went to the AIIMS in Delhi, which certified that he had suffered 100 per cent visual handicap.

Thereafter Gupta approached the NCDRC in March 2002. Gupta alleged that the doctors at Navjyoti acted against the advice of higher centres like Sankara Nethralaya and Retina Foundation, and their act was totally unscrupulous to extract monetary gain at the expense of his eyesight. He claimed Rs 1 crore compensation. Gupta died during the pendency of the complaint, but the litigation was continued by his heir.

Navjyoti doctors submitted that the patient was a known case of diabetes for 30 years. He approached them in 2000 for markedly diminished vision in both eyes, while he was under Laser (PRP) treatment elsewhere. They had advised immediate surgery of the left eye for vitreous haemorrhage. The decision to operate was taken to save his vision. They said the first surgery went off well and Gupta was satisfied, so he agreed to further surgeries. All the surgeries were successful, and Gupta gained some vision. Subsequently, he developed other complications which had no link with the surgery performed by them.

The NCDRC ruled, "There is no medical negligence – admittedly, the doctors are qualified doctors and they have used their best professional judgment at the time of treating the Diabetic Complications in the both eyes of complainant. The loss of vision was due to severity Proliferative Diabetic Retinopathy and not due to the mode of treatment or surgeries... We are also of considered view

that Referral is not abandonment."

ENT specialist treats burn injury patient, fined Rs 4 lakh for negligence

http://www.indiamedicaltimes.com/2014/01/10

New Delhi: The National Consumer Disputes Redressal Commission (NCDRC), while setting aside an order of the Bihar State Consumer Disputes Redressal Commission, held a doctor guilty of medical negligence and directed him to pay a compensation of Rs 4 lakh to a man who lost his hand due to his treatment.

NCDRC president D K Jain and members Vineeta Rai and Vinay Kumar, while hearing the revision petition, held that the Bihar State Commission erred in not correctly assessing and appreciating the evidence before them and erroneously concluding that there was no medical negligence.

The aggrieved, Jai Prakash Mehta, a resident of Bihar sustained serious burn injuries on his right arm due to electric shock while working on the electrification of a railway line as a contract labourer on June 26, 1998. He was taken to Dr B N Rai, an ENT specialist, under whom the aggrieved underwent treatment for over two weeks following which there was further deterioration of the burn injuries in his right arm.

Dr Rai then referred him to the Institute of Medical Sciences and Sir Sunderlal Hospital, Banaras Hindu University (BHU), Varanasi, where he was informed that gangrene had set in which could not be reversed and his arm had to be amputated.

Distressed by the medical negligence on the part of Dr Rai, which had very adverse and serious financial and emotional consequences for him, Jai Prakash approached the District Consumer Disputes Redressal Forum, Rohtas, Sasaram on grounds of medical negligence and deficiency in service and requested for compensation.

The District Forum dismissed the complaint on the grounds that there was no credible evidence to prove that there was any medical negligence on the part of the doctor and further that he was not a 'consumer' since no fees were taken from him by the doctor. Jai Prakash filed another appeal before the State Commission, which in its order upheld the findings of the District Forum.

Jai Prakash then filed a revision petition in the NCDRC, challenging the order of the Bihar State Commission.

The NCDRC in its observation stated, "The finding of the State Commission that no medical evidence was produced, including expert opinion, to prove that the medicines prescribed were not effective or incorrect is not tenable because this is a case of res ipsa loquitur, wherein the facts speak for themselves. If Petitioner had been properly treated for his serious burn injuries and referred in time to an appropriate health facility by the doctor, then gangrene and consequent loss of his right arm could have well been avoided."

It noted, "Clearly the doctor, who was an ENT specialist, did not have the professional competence and skills to treat the patient for burn injuries and instead misled him by assuring that the medicines mainly in the form of first aid treatment would lead to his recovery. It is clear that the Petitioner got wet gangrene because of the burn injuries which were not properly and adequately medically treated for over two weeks by the doctor."

Hawaii Dentist Sued by Family of Girl Left in Vegetative State after Root Canal

http://www.medindia.net/news 10.4.14

A lawsuit has been filed against Hawaii dentist Lilly Geyer and her practice, Island Dentistry for Children by the family of a 3-year-old girl, who claim that the dentist exhibited negligence and dangerous conduct that has left their daughter with irreversible brain damage.

Court documents allege that Finley Boyle received improper medications with incorrect dosages on December 3, 2013 as a result of which she "suffered severe and permanent brain damage."

"As a direct and proximate result of the medications administered to (Finley) by defendants, (Finley) suffered cardiac arrest during her dental procedure," the lawsuit said.

Finley's mother, Ashley Boyle, told CNN that she first took her daughter to the dentist in November when she was told that the girl needed 6 fillings and 4 root canals. The incident leading to the lawsuit took place in December when they returned for the root canals.

The lawsuit alleged that Finley was left unmonitored for 26 minutes following sedation and that Geyer's practice did not have plans or procedures to deal with medical emergencies. Finley's pediatric neurologist, Dr. Gregory Yen, said the girl was in a vegetative state and that it was difficult to predict how long she would live.

Research Briefs

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Traumatic brain injury: risks of epilepsy and implications for medico legal assessment.

Christensen J. Epilepsia. 2012 Sep; 53 Supple 4:43-7. Doi: 10.1111/j.1528-1167.2012.03612.x.

Traumatic brain injury (TBI) is one of the preventable causes of epilepsy. Increasing incidence among army personnel and the high incidence among children and young people raise concern. This article presented a review of studies dealing with the risks of TBI and the risk of posttraumatic epilepsy. The incidence of persons admitted to hospital with TBI has decreased in developed countries in recent years. The incidence of TBI-associated deaths has remained same and the decrease in hospitalization may merely reflect that more people with head injury are treated on an outpatient basis. Study made it clear that epilepsy is a frequent consequence of brain injury, even many years after the injury. However, there are several well-controlled studies that have been unable to identify therapies that prevent the development of epilepsy after TBI. Posttraumatic epilepsy has adverse implications for the affected individuals, family, and society. Despite several interventions used to prevent posttraumatic epilepsy, the only proven "intervention" to date is to prevent TBI from occurring.

Occupational rhinitis: consensus on diagnosis and medico legal implications.

Moscato G1, Rolla G, Siracusa A. Curr Opin Otolaryngol Head Neck Surg. 2011 Feb;19(1):36-42. doi: 10.1097/MOO.0b013e328341e228.

Work associated rhinitis is common disease among working groups and is frequently associated with asthma. The purpose of this review was to summarize the literature published on this issue in the past 12 months, to discuss the diagnostic workup and to highlight the medico legal aspects of this problem. Recently, there has been a growing interest in work-related rhinitis, which may include both occupational rhinitis and work-exacerbated rhinitis. The epidemiological relevance and the relationships to asthma have been evaluated. New etiologic agents and populations at risk have been identified. A new definition and classification, and a diagnostic algorithm, have been proposed. In consideration of the epidemiological relevance and of the medico legal implications, occupational rhinitis should be considered in daily clinical practice by all physicians. In adults with late-onset rhinitis, occupational causes should be sought and patients in whom an occupational association is suspected should be evaluated.

Professional Assistance / Welfare Scheme

1. The scheme shall be known as PAS **"Professional Assistance Scheme"**.
2. **ONLY the life member of IMLEA** shall be the beneficiary of this scheme on yearly basis. The member can renew to remain continuous beneficiary of this scheme by paying renewal fees every year. The scheme shall assist the member ONLY as far as the medical negligence is concerned.
3. This scheme shall be assisting the members by:
   i. **Medico-legal guidance** in hours of crisis. A committee of subject experts shall be formed which will guide the members in the hours of crisis.
   ii. **Expert opinion** if there are cases in court of law.
   iii. **Guidance of legal experts.** A team of Legal & med-legal experts shall be formed which will help in guiding the involved members in the hours of crisis.
   iv. **Support of crisis management committee** at the city / district level.
   v. **Financial assistance** as per the terms of agreement.
4. The fund contribution towards the scheme shall be decided in consultation with the indemnity experts. The same will depend on the type & extent of practice, number of bed in case of indoor facilities & depending upon the other liabilities.
5. A trust / committee / company/ society shall look after the management of the collected fund.
6. The Financial assistance will be like Medical Indemnity welfare scheme, where indemnity part shall be covered by government / IRDA approved companies or any other private company. The association shall be responsible only for the financial assistance. Any compensation/cost/ damages awarded by judicial trial shall be looked after by government / IRDA approved insurance

Admission Fee (One Time, non-refundable)		
1	Physician with Bachelor degree	Rs. 1000
2	Physician with Post graduate diploma	Rs. 2000
3	Physician with Post graduate degree	Rs. 3000
4	Super specialist	Rs. 4000
5	Surgeons, Anesthetist etc	Rs. 5000
6	Surgeons with Super specialist qualification	Rs. 6000

		Annual Fee for Individual	**Annual Fee for Hospitals Establishment**
1	Physician / doctors with OPD Practice	Rs. 60 / lakh	Rs. 340 / lakh + Re. 1 / OPD Pt + Rs. 5 / IPD Pt + 7.5 % of basic premium + Service Tax 10.3 % on the Total
2	Physician / doctors with Indoor Practice	Rs. 115 / lakh	
3	Physician / doctors with Indoor Practice of Surgeon	Rs. 230 / lakh	
4	Physician / doctors with superspecialty, Anesthetist etc	Rs. 340 / lakh	
5	✍ **Rs/- 1000 (One thousand) per year** shall be collected to develop the fund of the IMLEA towards emergency assistance, risk management and conducting trainings, CME, workshops etc. ✍ Physician / doctors visiting other hospitals shall have to pay 5% extra. ✍ For unqualified staff extra charges of 8% shall be collected. ✍ The additional charges 15 % for those working with radioactive treatment. ✍ The additional charges can be included for other benefits like OPD/ indoor attendance, instruments, fire, personnel injuries etc.		

companies or any other similar private company.

7. Experts will be involved so that we have better vision & outcome of the scheme.
8. The payment to the experts, Legal & med-legal experts shall be done as per the pre-decided remuneration. Payment issues discussed, agreed and processes shall be laid down by the members of these scheme.
9. If legal notice / case are received by member he should forward the necessary documents to the concerned person.
10. Reply to the notice/case should be made only after discussing with the expert committee.
11. A discontinued member if he wants to join the scheme again will be treated as a new member.
12. Most of the negligence litigations related to medical practice EXCEPT the criminal negligence cases shall be covered under this scheme. The scheme will also NOT COVER the damages arising out of fire, malicious intension, natural calamity or similar incidences.
13. All the doctors working in the hospital (Junior, Senior, Temporary, Permanent etc) shall be the members of the IMLEA, if the hospital wants to avail the benefits of this scheme.
14. The scheme can cover untrained hospital staff by paying extra amount as per the decision of expert committee.
15. A district/ State/ Regional level committee can be established for the scheme.
16. There will be involvement of electronic group of IMLEA for electronic data protection.
17. Flow Chart shall be established on what happens when a member approaches with a complaint made against him or her [Doctors in Distress (DnD) processes].
18. Telephone Help Line: setting up and manning will be done.
19. Planning will be done to start the Certificate/ Diploma/ Fellowship Course on med-leg issues to create a pool of experts.
20. Efforts will be made to spread preventive medico-legal aspects with respect to record keeping, consent and patient communication and this shall be integral and continuous process under taken for beneficiary of scheme by suitable medium.

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