*Editorial*

# Consumer Protection Law and the Pediatrician

*"... Thou shalt behave and act without arrogance and with undistracted mind, humility and constant: reflection, thon shalt pray for the welfare of all creatures..."*

*(Charak Samhita)*

The practice of medicine in India has undergone a considerable change during the last fifty years or so due to the effect of both positive and negative inputs in delivery of health and disease care. Reduction of mortality at all ages, increasing survival and longevity, availability of fruits of scientific and technological advances and a better quality of life, at least to nearly 20% of population, are some of the positive inputs. The negative inputs consist of deteriorating standards of medical college admissions and education, maldistribution of medical personnel in rural urban divide, commercialization of the vocation as an inevitable sequel of capitation fee phenomenon, lowering of value systems in society and impersonalization of medical services due to corporate culture taking roots in private health sector. Under these changing circumstances the spectrum of doctor patient relationship is also bound to change from all patients having full trust and blind faith in doctors to doubting Thomases who would expect a doctor to cure everyone and cry hoarse in cases of some deficiency or even unavoidable failures.

As the educational level, knowledge and awareness related to health issues increase in the population, expectations soar and a certain degree of accountability is naturally expected out of the practitioners even of the so-called noble profession. Despite the existence of acts such as Drugs and Cosmetic Act, Medical Council Act, and many civil and criminal provisions in law for a long time, this area of protection of a patient against harm coming to him from his doctor through acts of commission or omission had continued to remain neglected in India. The good old patient, under these conditions was bound to convert himself sooner or later into a consumer of medical services and seek protection under the Consumer Protection Act.

The Consumer Protection Act, 1986 (No. 68 of 1986) as amended by the Consumer Protection (Amendment) Act 1993 and 1994 has currently been into action to provide for better protection of the interests of consumers with provisions for establishment of consumer councils and other authorities for the settlement of consumer disputes and other matters connected therewith, applicable to the whole of India minus Jammu and Kashmir(l).

The medical fraternity's reaction to this act was an emotive one and they felt that the whole community was being termed delinquent and subjected to English legacy of the Law of Torts rather prematurely and unfairly in this country. Whether it was proper or not to bring the doctor-patient relationship to the level of master-servant or buyer-seller relationship (as envisaged in the act) also was the question. It does not require much guessing to visualize that in the long run, the average, ordinary and common patient is likely to suffer more from defensive practices than innovative treatments. All this thinking made medical associations challenge the inclusion of doctors under the purview of the act in the Su-

preme Court of India. This writ petition was rejected in 1995 and all doctors now are subject to provisions of the act with regard to grievances and redressal of their patients' genuine complaints.

As compared to previous instruments of justice against negligence, the Consumer Protection Act has been simplified with: *(a)* redressal at a better speed; *(b)* easy and a practicable procedure for application; (c) reduction in the cost to be virtually free; *(d)* provision for radical disposal; and *(e)* a further provision to prevent or action on frivolous complaints. In writ petition No. 3720/91 Mr R Raheja v/s MMC the High Court of Bombay has given a landmark decision that the patient or his legal heir has right to get copies of entire medical record on paymenj: of reasonable charges(2).

The main thrust of the act is on the legal right and *locus standi* of the consumer to initiate action under the act against deficiency in relation to any goods bought and/or any services hired against consideration (payment). Under this act, deficiency means any fault, imperfection, shortcoming, or inadequacy in quality, nature and manner of performance which is required to be maintained under the law or has been undertaken by the opposite party to be performed under the contract or otherwise. In relation to doctors, this concept of deficiency of services takes the place of professional or medical negligence(3).

Before a mountain is made out of the molehill of this concept by doctors, it must be clearly understood that the law expects each doctor to act, conduct himself and discharge his duties in such a manner as would be expected from a prudent peer of his in a similar situation having access to similar facilities and in the know of principles of such a practice in general, and not in the most ideal text book manner. While certain room does exist for variation in the management, based on many factors such as training, experience, *etc.* there is no escape or defence at all for recklessness, blatant dereliction of duty or misapplication of mind leading to negligent act due to errors of commission or omission.

Medical negligence is defined as a tort which breaches of a legal duty to take care which results in damage undesired by the defendent to the plaintiff. It takes notice of: *(a)* existence of legal duty to treat patient even by implication; *(b)* breach of the legal duty, if any, as compared to expected performance of his peer group; and (c) presence of damage caused by the breach which results in injury which needs to be compensated(3). Legal considerations in medical negligence cases generally are the following: *(a)* Use of reasonable degree of caution before embarking on treatment; *(b)* Whether there was a genuine error of judgement; *(c)* Day to day standard management; and *(d)* Palpably wrong diagnosis especially when not done in accordance with general or approved practice and acceptance of duty of care based on possesion of adequate skill and knowledge for that purpose.

As pediatricians caring for highly dependent consumers of medical services who have no direct choice in selection of their doctors, our perspective of this law has to be necessarily different as compared to those of our colleagues who cater to the adult population. The tightrope circus a pediatrician has to do is to simultaneously keep his own protective and selfdefending interest safe, also that of his little, innocent and delicate patient and at the same time practice rationally and innovatively while remaining within the framework of the consumer protection law.

As a part of one's own protection it is worthwhile knowing the etiological factors responsible for consumers going in for liti-

gation. Based on the experience of a consumer organization. Association of Consumer Action Safety and Health (ACASH), the following reasons have been leading patients to take recourse to consumer protection act against their doctors(4); (/) Intentional or unintentional instigation by other professional colleagues, occasionally rivals; *(it)* Communication failure with the patient like rudeness and nondisclosure of vital details of actions taken on the patient,or commercial attitude behavior; *(tit)* Poor and ineffective hospita[1] facilities; *(iv)* Substandard and defective equipment like nonworking oxygen, suction, *etc.; (v)* Absence of standard known and available treatment; *(vi)* Poor medical record keeping and failure or refusal to hand over copies of the same to the consumer; *(vii)* Indiscriminate use of high technology investigations without explanation leading to unexpected high costs to the consumer; and *(viii)* Non cooperation of senior pediatricians to give a clear and unambiguous expert opinion to the patient who would like to submit the same with his application creating a prejudice against the whole community of doctors. The most consistent finding in the above issues was that when ACASH counsellors interviewed the complainants at ease and with sympathetic attitude, many disputes got resolved at the source itself proving thereby that the major flaw in the situation was the lack of proper communication only.

One can devise one's own pattern as well as the Indian Academy of Pediatrics (IAP) can advise a collective action plan based on the experience gained till date. As an individual practitioner of the art of healing, we must accept that Indian people are very tolerant and generally respect and love doctors(5). Fears and apprehensions of being brought to book by the consumer court should not make a pediatrician hostile to his innocent client or ignorant and tense parent. We must not forget that unless there is a bond of love, trust and friendship between the patient and the pediatrician, the very foundation of pediatric practice, healing, would be extremely difficult. The best insurance policy that we can obtain against lawsuits is a genuine practice of compassion, personal interest and communication skills and creation of an environment where our special abilities can be shown to greatest advantage. Purely defensive and skihsaving practice will not be justified in our context.

The IAP as a custodian of interests of pediatricians and children of the country can take definitive steps and an action plan to keep ambulance chaser community at bay. In this context, the following recommendations were suggested by the participants of the IAP's National workshop on "Consumer Protection Act and the Pediatrician" held at Mumbai on October 10, 1996 for which the author was the convener:

1. Establish standards of treatment of common pediatric disorders as an official reference publication keeping in mind variety of Indian conditions of management.
2. Standard guidelines for investigations for various levels of practices of health care in India be formulated.
3. Undertake a study of infrastructural facilities in different parts of India and try to improve them through a process of backward integration.
4. Pressurize government and the industry to ensure quality control over the equipment that we use and drag them into litigation whenever necessary, if their contribution is realized to be causing harm to the interest of the patient.

5. Train members in the art of simple yet trasparent record keeping and it's benefits to all sections of population.
6. Train members in judicious use of high technology investigative procedure, laying resonable protocols wherever possible.
7. Insist on Medical Council of India to include communication techniques and skills and ethics as an important and mandatory subject in the under-graduate and post-graduate curriculum.
8. Provide management knowhow to members to develop simple machinery at personal and hospital level and a grievance Redressal Cell or forum to tackle with a potential problem of dissatisfaction on the spot.
9. Establish panels of volunteering experts at district, state, national and apex levels to assist public, doctors, consumer organizations and tribunals under the act.
10. Declare IAP as protector of child consumer in all aspects of child care, welfare, health and disease as its wide mandate in 21st century.

With globalization and liberalization, the medical profession too will come under pressure. Now is the time to think coolly and set our priorities right both individually and collectively. We should be the speciality which can lead others at this crucial juncture when fear and confusion seem to be clouding the minds of the intellectual practitioners of the erstwhile noble profession.

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