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Dr. Satish Tiwari, Yashoda Nagar No.2, Amravati - 444606. Maharashtra, India.

Disclaimer

Address for correspondence :
Dr. V. P. Singh
Professor, Forensic Medicine,
Old DMC, Civil Lines
Ludhiana, 141001. Punjab.
Email: singhvp@gmail.com
Mob.: 98154 77722

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Editorial :

Laws and Community Level Intervention for Protection of Children

*** Dr Yash Paul ** Dr. Satish Tiwari**

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Introduction:

Like all other living beings, human beings are also very protective of their young- ones. But sometimes due to some social or other reasons parent(s) may cause harm to the child, which may be physical or mental in nature. The injury caused may be mild or serious, at times resulting even in death.The harm caused can be put in two categories;

(I) Intentional and

(ii) Unintentional.

We are living in the era of Human and Child Rights. Universal Declaration of Human Rights and United Nations have proclaimed that children and childhood are entitled to special care and assistance [1]. The Convention on the Rights of the Child contains a comprehensive set of International Legal Standards for the protection and well-being of children [2]. Rights and problems of the children are attracting attention throughout the world. As young children are not able to defend themselves, roles of the government and the civil society become pertinent. The Government of India has established National and State Commissions for Protection of Child Rights.

One of the well-known examples of intentional harm is Medical child abuse or Munchausen Syndrome by Proxy. The parents simulate, fabricate or cause the disease falsely for medical attention [3]. From time to time the authorities have taken steps to protect children against intentional harm. Some examples are being cited:

1. **Female infanticide:** Jonathan Duncan who arrived in India in year 1772 and stayed till year 1811, established India's first Sanskrit College in Benaras, also stamped out female infanticide in Benaras and Kathiawar, (reported by the Times of India, Jaipur edition on 5th July 2021.)
2. **Orphans seeking donations:** Till the end of 20th century, children staying in orphanage used to walk on streets playing bands seeking donations from door to door. This humiliating act has now been stopped.
3. **Putting cradles near orphanages:** A child to be abandoned is put in the cradle and bell rung to inform caretakers, rather than throwing away or killed.
4. **Child Labour Act (1986):** This act prohibits employing any child below 14 years of age and employing (in hazardous occupation any child below 18 years of age) [4]. It includes begging by children. Punishment for violation of this act is imprisonment for 6 months to 2 years and fine of Rs.20000 to Rs. 50000.
5. **Sex determination of fetus:** Pre- conception and Pre-Natal Diagnostic Techniques Act 1994 (PCPNDT Act), with punishment up to 3 years and fine up to Rs. 10000.
6. **Protection of Children from Sexual Offences:** POCSO Act 2012- for protection of children from sexual assault, penetrative sexual assault, sexual harassment and pornography. The Act also provides for Special Courts establishment for trial of such offences [5].
7. **Tobacco and Alcohol** containing products not to be sold to persons below 18 years of age.

We would like to highlight some issues regarding un-intentional harm to the children which need interventions.

1. Road accidents: Incidence of road accidents is very high in India. During the year 2019 (before Covid-19 epidemic) there were 4,37,346 road accidents country wide and 1,54,732 people including 11,168 children were killed. We suggest following measures to reduce risk to children:

A. Extra penalty to be imposed for any traffic rule

* Practising Pediatrician, Jaipur Email : dryashpaul2003@yahoo.com

** Professor of Pediatrics, Medical College, Amravati; Email: drsatishtiwari@gmail.com

violation in case the driver is below 18 years of age.

B. Safety rules for school-going children - many children are reported getting injured and even killed while getting on or getting down from the buses because the bus driver moved the vehicle in a hurry. Many children are reported to get injured and even killed while crossing the road. Young children are not able to judge the time a vehicle moving in their direction will take to reach them.

Every vehicle carrying school-going children should be accompanied by a person - a conductor or a school teacher for safety of children. As the vehicle stops such person should get down from the vehicle first to help young children climb on or get down from the vehicle. In case a child has to cross the road and a family member or caretaker is not present, child should be escorted to cross the road. It should be made mandatory.

2. Bore-well accidents: From time to time there are reports that young children fall in bore wells. Some could be rescued while many die. According to the National Disaster Response Force (NDRF) over 40 children have died since 2009. Erection of meter high fence around the bore well and other wells should be mandatory.

3. Accidents in homes: An accident is defined as something unpleasant happening that was not intended causing injury or death. More than 50% injuries to children occur at home. For young children it may be falling from the bed or cradle, injury sustained by toys or sharp objects, drowning, swallowing harmful objects, burns etc. It is pertinent to state that in England and the US a child's falling from bed is punishable.

The Hindustan Times, Jaipur edition dated 17th October 2012 reported a case from US : "In August one year old Indrashish Saha was taken away from the parents as he had head injury which they held happened due to parental negligence. The Sahas maintained that the child was injured after he accidently fell from the bed. The child is in custody of the US child welfare authorities. The child's father and mother are allowed to visit him once a week for two hours. The family has forwarded four names to be considered as guardians to the US authorities".

Dainik Bhaskar, Jaipur edition (a Hindi newspaper) reported on 6th April 2014 a case from London, U.K." In year 2011 when Om was three months old, his mother had left him on the bed to attend a call by a person at the door. The child had fallen from the bed and was taken to the hospital where it was found that the child had a fracture in his arm. Hospital authorities informed the police who took the case to court. Court's verdict was that the "parents are not capable of taking care of the child so the child was handed over to the grandparents living in Pipli Gujarat, India. Parents are allowed to talk to Om on telephone but not allowed to visit him till he is 18 years."

Many would agree that the punishment meted out to the parents was very harsh. In fact it was a harsher punishment for young children for no fault on their part, as they were separated from the parents which is a great injustice to the affected child.

We agree that some sort of punishment may be given to the parents for their negligence. In our opinion there is a need to create awareness among people regarding safety of children. People should be educated through awareness campaigns that all medicines, sharp objects and harmful products like kerosene oil and phenyl etc should be kept beyond the reach of children. Both tubs and buckets should be kept empty as out of curiosity small children bend over buckets or tubs and because of heavy head and poor body control child may fall in the bucket or tub. Even one inch level of water can be dangerous. An infant should not be left on a bed or cradle without proper protection. In case mother has to attend some emergency work young child may be put on the floor. In case a child is injured in the home unintentionally, there should be some mechanism for counseling parents in the clinic or hospital where such child is treated.

4. Some harmful practices: Nomads, tribal and poor people use cloth hammocks as a cradle or carry bag put on back to carry children when walking. A hammock can lead to unsafe sleep position, child may fall, and in some cases asphyxia or suffocation may result in death of the child.

The Indian Express, Jaipur edition dated

15th July 2021 carried a report on this issue. It stated that the Thane Zila Parishad has started a 'Jholi Mukt Abhiyan' in the tribal pockets of the district to end the practice of carrying or resting infants in cloth hampers. The Women and Child Development department has decided to start initiative in the tribal areas and to extend it subsequently to other parts of the district. The department plans to provide cradles to such families with newborn babies and later take back the cradle once the infant has outgrown it to give the cradle to another family where a child has been born.

The above mentioned initiative by Thane Zila Parishad (Maharashtra) is a laudable act. National and State Commissions for Protection of Child Rights along with Indian Academy of Pediatrics and other stakeholders should deliberate upon issues of safety and well-being of children. We suggest posters regarding safety of children in local language be put up in schools and during Parents' Teachers Meeting (PTM) and counseling regarding child safety should be done. Periodically workshops and counseling sessions should be held in Middle and High Schools. ASHA workers should be trained and involved in spreading right messages in the community.

Child Line: Child abuse is universal and a worldwide phenomenon. A national child help-line is available for children in distress. Using the 24 hours service through a national toll-free number (1098) we can get urgent and emergency assistance or help - including medical help, protection from exploitation and abuse etc [6]. It also plays a major role in crisis intervention, long-term care and rehabilitation. It is operating in many cities across India [7].

Conclusion:

A child is the future of any community, state or country. Still, many children are neglected by most of us on many occasions. Even media, law makers, law monitoring or enforcing agencies exploit the children. There is need to sensitize media, press and society on these issues by making programs and giving guidance and information [8]. There are many issues related to the safety of children. It is pertinent to prevent the injuries to the children by providing a safe and healthy environment and surroundings. We should aim for child friendly environments/ communities. The government should look into various aspects of child rights and must be able to monitor the violations.

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Review Article:

Health as a Fundamental Right

Dr. Nidhi Yadav

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Introduction to Health

Health has been defined as a State of physical, mental, and social wellbeing of a person; a condition wherein a person is considered fit and healthy enough to lead a life free of any illness. Health is rightly considered the most important aspect of a good life.

Health is one of the most vital components of a living being needed to be maintained with utmost care. It should be protected to the full extent to help an individual live not only a disease or infirmity-free life but also essential for a life to be lived to its full extent. Hence, taking into account a holistic approach towards the wellbeing of a person, a person should be free of any disease or infirmity and should be physically, mentally, and socially healthy.

Now the question that arises here is to what extent the State is responsible to provide and protect the health of its citizens? Is the State legally and morally responsible to provide an ecosystem for the good health of its citizen? Does our Constitution bind the State to safeguard the health and wellbeing of its citizen?

Our judicial system has tried its level best to interpret the meaning of health under the light of the provisions under our Constitution. It was believed that such laws would improve the health care system of our country and also provide solutions to the present problems of the health care system.

Health and health law are two different concepts; health is a wider concept whereas health law includes rules, regulations, various laws, and bylaws focusing to ensure the best health care provided to the citizen of a country as their right and imposing a duty on the State to resolve health-associated issues. The development of health as a fundamental right and its growing importance globally has eventually developed the concept of the health law. As any law would need a modification as per the requirement and need of change in the society, health being the fundamental of human wellbeing, the health law is also undergoing a constant process of evolution from time to time. The historic evolution and development of health as a fundamental right is needed to be understood in light of different landmark judgments given by the Supreme Court and High Courts. Further, in International Law, health is recognized as a fundamental right, where the World Health Organization (WHO) in its supervisory capacity imposes an obligation on States to promote and protect the health of its citizens for the sake of humanity as a whole.

Meaning of Health and Healthcare

The definition of health given by WHO which is incorporated in the preamble of its Constitution is widely accepted all over the world as the baseline to achieve complete health of an individual. According to WHO, "Health is a State of complete physical, mental and social wellbeing and not merely the absence of disease". With time this definition has been extended to include economic and social wellbeing of the life expanding the scope and dimension of the health. Such inclusions by WHO have widened the vision of the system aiming to provide the best health care nationally and internationally covering various aspects of well-being. Social as well as mental wellbeing have overtly increased the responsibility, burden, and role of every health professional, them being typically in connection with the society at large.

Through this definition, WHO has given a positive expansion to "wellbeing" and is no more limited to the narrow perspective based on

* Consultant practitioner, Gurugram Email : yadav.nidhi0903@gmail.com

biomedical and pathology. Thus, World Trade Organization (WTO) has supported various health policies about the actions to be taken for the development of health and health care aiming to achieve the best possible vis a vis highest standard health care system globally. While elaborating the term highest standard of health care, through various interpretations of provisions under the Constitution of India, its scope has widened to all medical services, favourable working conditions, maternity leaves, sanitation, decent housing, adequate nutrition, sleep, and a clean environment. The right to health care to people directs that good quality medical services, doctors and nursing services (trained health care professionals), goods, infrastructure must be easily accessible and available at affordable prices and ideally provided by the public sector to all without any discrimination nationally at all times.

The health care system must be strategized in such a manner that it contains the following key standards as the human right to health[1]:

1. **Universal Access:** Health care should be provided by the public sector to all the citizens without any bias.
2. **Availability:** Adequate availability of medical services (primary, secondary, and tertiary health care), doctors and nursing services (trained health care professionals), goods (equipment's, drugs, instruments), infrastructure (hospitals, clinics, etc.) is a must all over the country without any discrimination.
3. **Acceptability and Dignity:** Acceptability refers to appropriate care in terms of culture followed by the patients, be approachable to health care needs based on age, sex, language, lifestyle, culture, and language. The maintenance of the dignity of the health care receiver by a health care provider is very important.
4. **Quality:** A health care system that is patient-centric must keep a quality check in terms of its safety, quality standard, control, and check mechanism.
5. **Non-Discrimination:** Bias in the health care system not only ruins the quality of the health care system but also encourages discrimination and brings social stigmas if practiced enormously and for an extended period in society. Hence it is relied upon that the public health sector should mainly deal with health care for the well-being of all the citizens of India irrespective of their socio economic strata.
6. **Transparency:** Transparency of health-related information, drugs related information (use and side effects), infrastructure and other healthcare system-related information helps to create more awareness amongst the people and allows for making a well informed decision about the health of the citizens and communities at large. Private and public sectors involved in providing access to such information can be held liable if transparency is not maintained to safeguard the right to health.

Evolution and Development of Health as a Fundamental Right:

Right to health has been evolving for so many years through various legislations, interpretations and developments in the field of health. The evolution of health as a right can be traced back from the pre-independence era and it continues to evolve even now [2].

1. Nehru Report,1928

This report was given in the Parliament to propose the State for the formation of appropriate laws in the domain of welfare and wellbeing of mother and her child, financial welfare of unemployed, old, diseased,and dependent population

2. Karachi Report,1931

This Report carried the resolution which tailed the footprints of Mahatma Gandhi for outlawing the intoxication of drinks and drugs. The socio-economic provisions in the Karachi Resolution went on to influence the Constituent Assembly in framing Part IV of the Indian Constitution – the Directive Principles of State Policy (DPSP). DPSP in the Indian Constitution reflects that India is a welfare State. This report consists of several recommendations to parliament to make laws relating to healthy working conditions, minimum wages, limiting working hours, financial welfare of old, diseased,

unemployed, and dependent population, maternity leave, and protection to women at work and prohibition of child employment in factories.

3. Draft of Constitution of Free India (M.N.ROY), 1944

This draft restricted the hours of work to eight hours per day for six days per week, allowed one month full paid leave every year and also included three months of full paid maternity leave for women workers.

4. Right to Health and Preamble Under The Indian Constitution

The preamble of the Constitution was adopted on November 26, 1949. "The Preamble to the Constitution declares India to be a sovereign, socialist, secular, and democratic republic". Socialism can be achieved by the co-existence of the private and public sectors democratically. Socialism is best practiced in an egalitarian society and such rights should be valued equally without compromising on the dignity of an individual.

The term Socialist was an addition made in the Preamble by 42nd Amendment, 1976. This inclusion is made in part III and part IV of the Indian Constitution.

Hence India is a welfare State with a socialistic pattern of society under Article 21 of the Constitution[3], which guarantees the right to life and personal liberty, the domain of which has been extended to provide health as a fundamental right by focusing on the improvements of health care system of India.

Modules of Right to Health

Following are the major constituents of the right to health:

a) **The Right to Appropriate Health Care –** The "appropriate health care" includes good quality health facilities inclusive of all services provided by hospitals and good quality drugs. The equal accessibility, affordability, and availability of "appropriate health care" holds a very important role. Such facilities shall provide a holistic approach towards all kinds of treatment whether preventive or curative to all the people in the country.

b) **Right to an Adequate Supply of housing, Food, Nutrition, sleep, and water–** Adequate and good quality food and nutrition, sanitation, water, sleep and housing are the basic requirements for an individual to live a healthy life.

c) **The Right to Healthy and Safe Environment and Healthy and Safe Working Conditions-** This includes an environment that is free from pollutants in water, soil, and air; prohibition of occupational hazards to provide a safe workplace environment. This will help an individual to live a healthy life.

d) **The Right to Maternal, Child, and Reproductive Health-** The reproductive life of a woman including her maternal well-being should be respected and protected along with her child's well-being. Ensuring a safe reproductive life is considered an important constituent of health. Provisions have been made focusing on child's health and improving health care services not only for mental well-being but also for sexual and reproductive well-being. Such special provisions also highlight the preventive and curative measures to be taken to improve women's health in toto.

e) **The Right to Participate in Health-Related Decision Making-** The participation of the community in "setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health" which includes participation in the "provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in specific, participation in political decisions about the right to health taken at both the community and national level" is very important to achieve a better health care system and to promote the well-being of people effectively.

f) **The Right to Access Health-Related Information –** the access to information related to health does not only mean accessibility and promotion of health education and medical research but also includes dispensing information related to all the health concerning issues, use, and misuses of drugs, availability of

health facilities, various modes of prevention and treatments including traditional practices.

Directive Principle of State Policy and Health

DPSP is included in part IV of the Constitution of India which concludes that India is a welfare State. DPSP lays down fundamental principles which are being followed by States by making various laws and policies supporting these principles which is the core of Article 37 of the Constitution of India[4].The citizens of the country can keep a check on the State through the functioning or non-functioning of the principles laid down in DPSP providing scope and enthusiasm for improvement. Incompetency of following the DPSP by the government would affect the Fundamental Rights directly or indirectly. Hence DPSP is the pre-eminence of Fundamental Rights. The objective is to provide a good life to the citizens which not only includes social and economic life but also a healthy life.

According to Article 38 of the Constitution of India[5], States shall safeguard the social order in the purview of the welfare of the people which also includes public health as the welfare of the people cannot be completed without taking the health of the public into account. Article 39(e) of the Constitution of India "protects the health of the workmen and strength of the workers that they shall not be forced to pursue any vocation unsuited to their age and strength by economic necessity"[6].

Article 41 of the Constitution of India provides that "the State shall within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want"[7]. This corresponds to Article 6 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)[9]. Article 42 of the Constitution of India States that "the State shall make provision for securing just and humane conditions of work and for maternity relief."[9].

The DPSP under Article 47 of the Constitution of India States that "the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health."

Article 48A of the Constitution of India ascertains to protect wildlife along with safeguarding the forests and ensures a healthy, pollution-free environment for the entire population of the country [10].

The Constitution of India also gives power and authority to the Panchayats and Municipalities to function as self-government for economic development and social justice under Article 243G of the Constitution of India[11]. (read with Entry 23, 11th Schedule, The Constitution of India[12].

The aforementioned articles of the Constitution of India laying important principles of DPSP cannot be achieved without having optimum materialistic resources amongst the massive population of India. State agencies like the food corporation of India must work in conformity with Article 47 of the Constitution of India[13] both in the letter and spirit to enhance public health by keeping a check on the quality of food and ingredient of food ultimately creating a compulsion on the State to ensure such actions to be taken.

The State shall frame the laws to prohibit child labor and protect the right of women to work by providing maternity leave. To the general welfare of the workmen, it has also been submitted as the principle of DPSP to preclude the maximum working hours of the workmen along with the laws laid on the paid and non-paid leaves. Not just to secure the right to work, the right to education has also been a principle of DPSP for which various policies have been laid down from time to time to enhance the availability and quality of education so as to make citizens aware towards their wellbeing and health. The State has been taking up the responsibility to assist the public in cases of sickness, joblessness, old age, disability, and other financially dependent and deprived cases. Such circumstances have a direct or indirect impact on the wellbeing of a persona and also on the community at large.

Article 51A of the Constitution of India[14] imposes all the obligations as duties of the State not along with duties of the citizen related to all the rights enjoyed by the citizen. Rights and

obligations are inseparable, deeply connected, and are dependent on each other.

Fundamental Right and Health

The DPSP are the guidelines to the State but are non-justifiable. A person cannot claim for non-functioning of such guidelines. **In CESC Ltd. vs. Subhash Chandra Bose**, the Supreme Court laid that right to health is a fundamental right by relying on international instruments. Article 21 of the Constitution of India States that "no person shall be deprived of his life or personal liberty except according to procedure established by law". The right to life is not only limited to the mere survival of an animal or a human being but also extends to the life to be lived with dignity and integrity. Through innumerable case laws, the supreme court has confirmed time and again that health is a fundamental right, though not exclusively mentioned under Article 21 of the Constitution of India. Article 23 of the Constitution of India is incidentally related to health. Article 23(1) of the Constitution of India prohibits trafficking of human beings and forced labor, any act in contravention to it is punishable as an offense as per law[15]. Trafficking of women promotes prostitution which in turn is a major cause behind the spread of AIDS, hence indirectly related to the health and wellbeing of a person and the community in general. Trafficking of children leads to child labor and forced labor which is also related to the health and wellbeing of a child. Article 24 of the Constitution of India provides specifically for child labor stating that "no child below the age of 14 years shall be employed to work in any factory or mine or engaged in any other hazardous employment"[16]. Article 25 and Article 26 of the Constitution of India provide and protect the right to practice and profess the religion of one's choice. This right is being given to every person on the land and not just citizens of India provided the right must be enjoyed following public order, with morality and health along with other provisions of the Constitution without adversely affecting the right of the others.

Fundamental Duties and Health

The fundamental duties of a citizen are Stated in Part IV of the Constitution of India. Article 51A of the Constitution of India provides a detailed list of Fundamental duties that are considered as an obligation upon a citizen of India so that he can thoroughly enjoy the fundamental rights provided by our Constitution.

Article 51A sub-clause (g) of the Constitution of India mandates duty not only to the State but also imposes a duty on the citizens to preserve, maintain and enhance the natural environment and be compassionate for other creatures on the earth[17].

Out of all the duties mentioned in Article 51A of the Constitution of India, there are a few of them which are important from the perspective of life and well-being of a person which is mentioned as the duty of a citizen to protect and improve the natural environment including forests, lakes, rivers, and wildlife, and to have compassion for living creatures and promote harmony of common brotherhood providing social wellbeing. It also mentions a duty to forsake practices that are offensive to the dignity of a woman. These duties are very closely related to the overall wellbeing of a person and society in general.

Local Self Government and Health

The local and self-governments are the Panchayat and Municipality which have the authority to improve and protect the wellbeing and health of the people by the powers conferred to them through the State Legislature mentioned under Article 243G of the Constitution of India. Article 235 G of the Constitution of India says that the legislature of a State may endow the panchayats with necessary power and authority concerning matters listed in the eleventh schedule. According to Article 243-W of the Constitution of India, the municipalities and committees have been given powers and authorities by the State Legislature which allows them to work as an institution of local self-Government[18].

Right to Health Care as a Fundamental Right

The health of an individual is of the utmost importance. It is a well-known fact that the health of a person is something that stays with the individual till he is alive hence needs to be taken care of to its best. The pain and suffering of a person cannot be shared by any other person as pain and suffering belong to an individual. Hence it is of paramount importance to pronounce health as a fundamental right globally.

India is a welfare State. It is the key duty of the government to secure the welfare of its citizen. The apex court has widened the meaning and scope of health as a fundamental right under Article 21 of the Constitution of India through various judgments. Apex court in its landmark judgment laid that it is the accountability of the government to provide medical facilities to every person in a welfare State.

The fundamental right to health is an extension of article 21 of the Constitution of India which protects human life in general. The public sector has laid foundations of the various hospital to serve this purpose so that timely treatment can be provided including all medical facilities required by a person to live a healthy life. If the public health sector is unable to provide such facilities, it will be depriving the person of his fundamental right to health guaranteed under Article 21 of the Constitution of India.

Concerning serious medical illnesses, the court has laid down certain guidelines:

a. Basic necessary treatment should be provided by public primary health care centers comprising of adequate facilities to stabilize a sick patient.
b. In case of serious illness, the patient shall be treated at a primary health center in various districts and sub-divisional level hospitals. Hence such facilities should be available in those hospitals.
c. The primary health care center should provide specialist treatment facilities as per the growing need.
d. In case of emergency, there should be a centralized gateway connection system with the help of which the availability of an emergency bed can be marked out immediately so that patients can access the emergency treatment at the earliest without any undue delay.
e. There should be adequate ambulance transport facility available for those who are sick not just to bring the patient to hospital but also to transfer the patient from one hospital to another to provide the best care and treatment to the patient.
f. All ambulances should contain all the necessary equipment and a doctor or a nurse or both needed to stabilize the patient on the way to the hospital.

Judicial Precedents and Health as a Fundamental Right

With the fundamental right to life being recognized in India under its Constitution, health is being paid more attention ever than before. In Article 47 of the Constitution of India, it has been mentioned that it is the primary duty of the State to maintain the level of nutrition along with the standard of living for its citizens bringing the improvement in the health of its people. In **Ratlam Municipal Corporation v. Vardhichand,** the court affirmed that maintaining the healthy living conditions of the people is the primary duty of the State under Article 47 of the Constitution of India and the State also enforces such duty against any authority or government body.

In the case, **Bandhua Mukti Morcha v. Union of India,** it was held that although the DPSP Policy is very persuasive, yet their operation is not guaranteed by the State and this case interpreted dignity as well within the ambit of Article 21 of the Constitution of India. Since no one can sue the State for noncompliance with DPSP, the application and enforcement of the principles and guidelines set out by DPSP are always in question. While expanding the meaning of the right to life, the right to health was considered a major factor that is to be maintained to ensure that human life is being lived with dignity as well. In a famous case **Consumer Education and Research Center v. UOI,** it was held that the right to health includes the right to medical care as a fundamental right provided under Article 21 of the Constitution of India as an extension of its scope.

It is a legal fact that every right of a person is correlated with a duty laid upon an individual, or a State as defined in article 12 of the Constitution of India. This was re-established in one of the cases **State of Punjab v Ram Lubhaya Bagga** where it was laid that the right to life imposes a responsibility on the State. The State has to protect the well-being of its citizen which is being

reinforced by Article 47 of the Constitution of India. This duty can be well performed by building up an accessible good quality public sector health infrastructure. Since this is an obligation on the government or authority, it is obvious that the people of the country would accept the fulfillment of such duty from the State itself. Health is the ultimate priority of every individual, contentment and completion of such duty by a State cannot be neglected and has to be the priority of the State.

This is beneficial to citizens as well as the State in attaining political as well as socioeconomic goals.

Domains of Health and Health Care

The right to health being a non-enforceable DPSP has been interpreted as a fundamental right by the Supreme Court and while doing so it also defined health and healthcare through a series of cases.

a. Right to Healthy Environment

The Supreme Court in the famous case of **M.C. Mehta v. Union of India** held that people have the right to a healthy environment and it is a part of the right to life as guaranteed by Article 21 of the Indian Constitution.

It is the duty of the citizens as well as the State to protect the environment and keep it free from pollution. Also, pollution is a growing cause of many diseases and is considered a slow poison to mankind. Hence if the environment is not protected it will be a violation of Article 21 of the Constitution of India **(In T. Ramakrishna Rao v. Hyderabad Development Authority)**

b. Right of Elderly to life care and health

In the case of **Dr. Ashwani Kumar v. Union of India29** decided that the elderly have a right to geriatric care and medical facility which should be provided by the State along with Pension and shelter to maintain their health and provide better healthcare. Further, the State must look for effective implementation of the Maintenance and Welfare of Parents and Senior Citizens Act,(2007).

c. Right to sleep

The courts have recognized the right to sleep as part of the right to health once in **Churches of God v. KKR Majestic Association.** However, the major recognition was brought on later in the case of **Ramlila Maidan Incident v. Home Secretary and Ors (2011)** where courts held that an individual is entitled to sleep comfortably and as freely as he breathes. It is essential to maintain the delicate balance of health necessary for its existence and survival. Thus, sleep must be regarded as a fundamental ingredient of health.

d. Right to healthcare facility in Train

In **Ram Dutt Sharma v. Union of India,** Railway Board has given instructions to the zonal railway for the reservation of coupe for births during a long-distance journey. Publicize the availability of medical coupe attached with the train during long distance to provide for people need during travel. The healthcare is to be provided free of cost by a competent doctor, guidelines issued also include the required individuals in a medical team who is to be present in the train and their efficient rooster planning.

e. Right to Public Health

It was in **Ratlam Municipal Corporation v. Vardhichand**, the Supreme Court widened the scope of healthcare as a fundamental right to public health.

f. Right to access to medical care

In **Consumer Education and Research Centre v. Union of India**, the court emphasized that the right to health is an important factor of a meaningful and purposeful life to cover it within the ambit of Article 21. Court also added that there should be access to a good quality standard of medical care as an inclusion to the right to health.

g. Right to emergency treatment

The Apex court in **Parmanand Katra v. Union of India** held that emergency treatment should be given to the patient immediately without wasting the golden hours of the patient. Other legal or medical formalities cannot be given priority over the first aid or treatment required for stabilizing the patient.

In the above case, the honorable supreme court

also held that it is of prime importance to protect the innocent health professional from legal impediments. The unavailability of timely treatment in a government hospital is considered a violation of the right to life.

h. Right to availability of facilities in hospitals during an emergency:

In **Paschim Banga Ket Mazdoor Samity and Ors. v. State of West Bengal** case, the court upheld that it is the obligation and responsibility of the government to provide optimum medical aid to its citizens thus widening the ambit of article 21 of the Constitution of India.

i. Medical facilities as a part of Social Security reference

In **CESC Ltd. v. Subash Chandra Bose,** the court affirmed that health does not mean the absence of infirmity or disease. Also, health facilities at work are considered as an incentive for workers to maintain their mental and physical health which helps them to bring out maximum productivity. Hence, medical facilities can be considered a part of social security.

j. Prohibition of commercialization of transplant

In the case of **Spring Meadow Hospital v. Harijol Ahluwaliya**, the apex court discussed the need for relevant law about the right to health for which it was ordered that there shall be an act to deal with legal prohibition of commercialization of transplant. Thus, to life, this case yet again recognized the dignity and fundamental right of life leading to the recognition of the importance of health.

k. Right to water

Kerala high court in **F.K. Hussain v. the State of Kerala** firmly said that to attain and maintain the health of any individual, the right to clean water is a must.

l. Right to special treatment to children in jail

In the case of **R.D. Upadhyay vs State of A.P. and Ors**, the Supreme Court Stated that every child has a right to basic necessities like proper nutritional food, sanitation, education, etc., and should receive such minimum facilities irrespective of the fact that they are in Jail.

m. **Right against inhuman conditions in after-care homes:**

In the case of **Vikram v State of Bihar,** the Supreme Court of India ordered the State government of Bihar to take all needed measures to enhance the conditions of the care homes for the complete wellbeing of women and children. The State government was directed to make arrangements for proper housing, sanitation, clean water, and adequate electricity supply, etc. The Supreme Court mentioned that "the right to live with human dignity is the fundamental right of every Indian citizen" and that the State must abide by "Constitutional standards" and provide "at least the minimum conditions ensuring human dignity."

n. Health rights of mentally ill patients

In the case of **Chitta Ranjan Bhattacharjee V. State Of Tripura And Ors 17 December 2009** it was Stated that "the mentally ill persons are to be treated like any other sick persons and as far as possible the environment around them should be made as normal as possible utilizing the advantage of medical science".

o. Rights of patients in cataract surgery camps

In the case of **A.S. Mittal v State of UP,** the court emphasized that the need for aseptic and sterile conditions for ophthalmic surgery. Court also mentioned the importance of professional commitment with which prescriptions are implemented that the ultimate result rests.

p. **Right against occupational health hazards: In Consumer Education and Research Centre v Union Of India,** Hon'ble Supreme Court held that "the imposing necessity to work in an industry which is open to health hazards due to needing to earn bread for himself and his dependents should not be at the price of health and vigor of the workman".

q. **Right to availability of blood products**

In the case of **Common Cause vs Union Of India And Others**, it was Stated that high-quality blood and blood components in adequate quantity will be made available to all users.

r. **Prohibition of smoking in public places**
In the case of **Murli S. Deora vs Union Of India And Ors** after realizing the gravity of the situation and considering the adverse effects of smoking on smokers and passive smokers the court issued directions to ensure prohibiting smoking in public places.

s. **Rights of HIV/AIDS patients**
In the case of **Mx Of Bombay Indian Inhabitant v. Zy And Another**, the court decided that a person with HIV could perform normal job functions provided that the risk of transmission to others is minimal or absent at the workplace.

t. **Right to Sanitation:** Sanitation is a State subject. In the 73rd Constitutional amendment, panchayats were given responsibility for maintaining sanitation in local rural areas. Swachh Bharat Abhiyan in 2014 aims at keeping India clean which includes the construction of toilets in rural areas and school all over the country. In the case, **Virender Gaur And Others v. the State Of Haryana And Others Supreme Court Of India** [19]. It was Stated that sanitation is something without which life cannot be enjoyed.

Recommended Framework of Right to Health

The principle of solidarity:

The principle of solidarity can be well seen in the prospects of the right to health. The solidarity put forth the concept that there should be equal access to the health care system to all irrespective of caste, creed, sex, race, religion, and language maintaining the dignity of the people. Solidarity for the right to health is to be practiced while respecting the various cultures in different parts of the country. This principle is also connected with the fundamentals of equity and justice. The communities which are located distantly have suffered from a lack of adequate health care and other basic necessities of living during the pandemic of COVID-19. This has marked the level of equality that is currently prevalent in India. To maintain the principle of solidarity in our country, the State government shall look for solutions to the common problems being faced for the benefit of all citizens at the State and Central levels[19].

The doctrine of proportionality:

It is the method to calculate the balance between the limitations inflicted by the State for remedial measures to be taken and the extremity of restrained acts. It determines the limitation of rights that are Constitutionally protected. During COVID Pandemic, the government has imposed certain measures such as complete lockdown, partial lockdown, mandatory quarantine, and enacting various laws including criminalization of various acts like noncompliance with government policies and guidelines. Such restrictions have been widely considered as unreasonable infringement of the right to livelihood and civil liberties. While such restrictions are understandable but no measures can be taken keeping in mind the doctrine of proportionality.

Such hard decisions need not be a step towards success in such circumstances but a systematic holistic approach keeping in mind the general health and welfare of the public and community at large can be a successful approach to move forward with.

Few Asian and European countries did not take very restrictive measures against the containment of COVID 19 infection yet they are successful in controlling the spread of the coronavirus.

The principle of transparency:

This principle is important to build up the trust of citizens in public administration. The information should be available, accessible, and must be easily spread among the population. This principle is directly proportional to accountability and reliability. The overpricing and authenticity of drugs and availability of medical services can be controlled well if transparency is maintained concerning the right to health and health care. Transparency also helps in maintaining the optimum functioning of the institutions governed by the public sector which in turn helps in increasing the trust of the people. The recent use of the Arogya Setu app in tracing the patient infected by COVID 19 and further tracing the close contact of such patient is one recent example where

transparency has helped various citizens from getting infected.

Public Health and Situation at Present

Public health and sanitation, hospitals, and dispensaries are the subject matter of the State[20]. . It has been very recently reported by the NITI Aayog report in 2019 that the public health system has been unequal due to limited expertise and limited budget. Minimal GDP has been spent on the public health sector by our government (1.8 percent of GDP on health in 2020-21)[21]. The recent debate that has come up is what if public health has been made a matter of union list or concurrent list? Would it be beneficial especially in these uncertain times of pandemic COVID19? The answer is not straight but can be more justified to include it in the concurrent list so that the policies can be effectively followed and financial restraint would be less of a hurdle. However, the possible drawback of such change can be red tape, inappropriate bureaucracy, and other governmental constraints. Such a shift may also not be able to provide focused attention to each different State in our country[22]. It is pertinent to mention that this year the "Government of India approved the continuation of 'National Health Mission with a budget of Rs.37,130 crores (US$ 5.10 billion) under the Union Budget 2021-22".[57]As per the Union Budget 2021, "the Ministry of AYUSH was allocated Rs.2,970 crores (US$ 407.84 million), up from Rs.2,122 crores (US$ 291.39 million)"[23].

By obscuring cooperate federalism on the matter of health, both center and State governments may work together in harmony for the wellbeing of the people of India. During the COVID 19 pandemic, it has been observed that there is a desperate need for improvement in the infrastructure of healthcare at the various center, districts, and local levels. It was also noticed that during the second wave, the hospitals governed by the central government did not face the shortage of oxygen supply as much as the State government and private sector hospitals faced being covered by the different channels of oxygen supply as compared to other hospitals.

Whereas the other school of thought that gives priority to health being a State subject defends it by the various success that States have gained during various challenges like invoking The Epidemic Act 1897 in Maharashtra and New Delhi and later the National Disaster Management Act, 2005 was invoked by the center Government. The State has to provide health services to the citizens. India is also bound to provide a minimum standard of universal health care being a committed member of the UN further strengthens the concept of health as a fundamental right in India.

Development of Ayushman Bharat scheme:

It is one of the major actions taken by the central government. The Ayushman Bharat scheme (AB PM-JAY) was launched on 14th September 2018 where the health insurance is provided to a family of up to 5 lakh rupees without any cap on the number of family members. This scheme was completely based on the public health sector but private hospitals were also made a part of it. Until the COVID pandemic, it was seen as a successful program but during a pandemic, it has been going down the drain as this scheme was unable to function well during the pandemic. Under AB PM-JAY, 21,573 hospitals were empaneled as of 23-05-2020 out of which 56% were public and 44% were private hospitals. Before lockdown in 2020, 51% were active (59% public and 66% private active hospital) and during the lockdown, this dropped to 25% hospital being active noticing a fall of 40% active hospitals. Most affected hospitals were small and medium sized (100 beds or less). This decreased in hospital activity was noticed due to fear among staff, doctors, and administrators of being infected with COVID-19. The possible reason behind this decrease in active hospitals is limited availability of workforce and scarcity of resources for handling the treatment of COVID 19. Another possible reason can be an overflow of positive cases and limited resources due to which most of the hospitals did not book themselves on the AB PM-JAY IT platform. Due to the limited resources availability and high demand of hospitals, the

hospital overcharges the patient for the treatment provided. It is worthwhile to mention that due to the scarcity of medical equipment, increasing cost of patient service in non-COVID cases, only a few hospitals were able to function during the COVID pandemic.

With the beginning of the COVID-19 pandemic, to control the infection of the Coronavirus lockdown began across the globe. In India, Lockdown was not only difficult to implement but also was not taken well by the citizens due to infringement of the few fundamental rights. The State Government was directed by the Central Government to ensure that all workers are being paid their wages without any deduction in any circumstances without undue delays thus preserving the right to life. In **Peoples Union for Democratic Rights v. Union of India,** it was held that non-payment of minimum wages to employees is an infringement of their right to life under article 21. However, few corporations, industries and professions, and other sectors have violated these practices by laying off, delay in payments, and reducing wages.

In the current pandemic, Front line workers are also equally entitled to the right to health but due to inadequacies of PPE, testing kits, and medical apparatus, they stand at a higher risk to contract the infection. This lack in infrastructure and supply is a threat to their health for which State is responsible for the incompetency to provide the barely minimum facility of protection to frontline workers in the pandemic. Covid-19 makes the healthcare workers and frontline workers fall under the contours laid down in the CERC judgment, thereby making the lack of PPE, testing kits, and medical apparatus a grave violation of the Fundamental Rights of the healthcare workers **(CERC and others v. Union of India and others)**

This COVID 19 pandemic has also deprived adults and children of the right to education. In India not all people can afford the expenditures on the technology and scarcity of availability of internet in a rural area is a well-known fact in areas where the cellular network also fails most of the time. In such circumstances, students have been deprived of the education and methods of online learning introduced due to the closure of educational institutions since the beginning of the pandemic under the orders of the State government. This is a deprivation of the right to education to all the students in the country. For the poor, the mid-day meal was an inducer to visit the school for education which served the dual purpose of providing nutrition and education, which has also failed during a pandemic.

From the perspective of the right to food, the State government has been unable to provide food to the poor and those workers who migrated and do not possess a BPL card are unqualified to avail the government services of receiving ration from ration shops.

The application Arogya Setu which came into existence with the mere agenda of tracing the infected patient and the close contacts so that others can be saved from contracting infections from them has eventually infringed the right to privacy of each person who downloaded the app. The personal data of people was used without taking the consent of the person. The State government released the data of all who were quarantined. The personal data included name, passport number, address, and phone number. Hence the State must protect the right to privacy of everyone and ensure that the data is being used systematically for the record.

Conclusion and Suggestions

The Right to Health is not an exclusive and independent fundamental right. It is provided as a DPSP in Chapter IV of the Constitution of India. Being a DPSP, the policies and guidelines enacted by the State are not justifiable. The Right to Health has been brought under the ambit of Article 21 of the Constitution of India which also talks about the Right to Life and Liberty. Various precedents of court have widened the scope of the Right to Life and extended it to the various ambits of health consequently providing the Right to Health a pedestal equivalent to a fundamental right. Public health and sanitation is the matter of State list in schedule 7 mentioned in entry 6. During the Pandemic of COVID19, the debate of bringing

public health and sanitation under the ambit of a concurrent list has risen. Such a shift may help bring the changes needed in our health care system. Linking the public health sector with the private health sector as done by Ayushman Bharat Scheme has ensured a better healthcare infrastructure. During the pandemic of COVID19, we the people of India have seen the health infrastructure getting doomed, simultaneously we have also seen many other fundamental rights being infringed like the right to health, right to livelihood, right to food, right to privacy, right to minimum wages, right to education by the improper functioning of the government and the laws enacted by the respective government over the citizens during a pandemic. However, it is pertinent to note that during the second wave of the COVID 19 pandemic the hospitals and entire healthcare infrastructure was overburdened and overwhelmed due to the vast amount of cases seen considering the severity of most of patients conditions but if the government would have taken strict measure following the first waves the second waves could probably have been controlled better or the government could have been better prepared for it if the infrastructure would have been improved.

However, the other school of thought which is prevalent is that the Covid19 pandemic cannot be taken as a violation of the fundamental right to health as it is not just any normal situation, rather it is a pandemic for which no one can be prepared as much in such a short period. Though a lot of strict measures could have been taken to prevent the spread of the second wave. Since it is very difficult to find and control the source and the spread of the virus, no blame game would have helped any better to overcome the effect of the pandemic.

We have also seen the direct impact of the minuscule budget that our government has spent on the health care system which needs improvement so that an adequate health care facility can be provided. The significance of the application of improved enactments and guidelines should also be a foremost priority while other steps are done effectively.

Suggestions

a) It is high time that the right to health should exclusively be written down as a fundamental right under the Constitution of India so that it can be enforceable by the court. The right to health should be provided to every person on the land and not just the citizens of India.
b) The policy of proportionality, solidarity, and transparency should be the basis of the framework of the right to health and health law.
c) It is recommended to make most of the public sector health care system equipped with all facilities which must be accessible to every common man living in the country even in the rural area and tribal areas.
d) Ideally, the health care system should completely be a public health care system so that all the citizens can be treated equally without any discrimination of socioeconomic strata.
e) The government should fairly calculate the optimum GDP to be spent on the health care system taking into account various factors like age and socioeconomic conditions of the citizens and further increase the GDP to build adequate good quality health care in India.
f) The administration departments affiliated with the health care system of India should evolve, understand their responsibility, and function adequately in a more serious manner considering the need for change in the health care system from time to time.
g) Government should receive suggestions to bring changes needed in the system to improve healthcare holistically in India.

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Review Article:

Competency Based Health Assurance

Dr Sumanta Ghosh Maulik

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Abstract : Background:

The National health Policy 2017 has been introduced with the objective of bringing in a paradigm shift in the national health planning and execution due to emergent trend of rising non-communicable diseases, expression of interest of the corporate sectors in healthcare investment and acknowledgement of Corporate Social Responsibility on one hand and declining trend on Infant & maternal Mortality as well as communicable disease burden in the country. The Ayushman Bharat (PMJAY) is a definitive step in this aspect to ensure Availability and Accessibility of Quality health care in an Affordable manner for almost 40% of the country's population. Three of the MDG are directly related to Health, Maternal and child care & communicable diseases including Malaria, Tuberculosis and HIV/AIDS, with COVID 19 being the fourth most probable inclusion in days to come. However, in it's zeal to win the hearts of the electorate, the Government hate raised their "legitimate expectations", but never dared to induce them towards performance of their common minimum duties that can fuel a remarkable acceleration in achieving the target attributes set by the Government within a stipulated time.

Objective:

The present paper tries to focus on the current performance of different states and Union territories towards implementation of Ayushman Bharat Programme, along with establishment of a linkage with the feasibility of attainment of MDG parameters vis a vis, trying to formulate a mechanism, which can provide an impetus to the common people in improving their stake in the PMJAY by following some guided lifestyle modifications, which will ultimately enable them to individually contribute towards collective attainment of target parameters of National Health Policy 2017.

Conclusion:

Critical analysis of the policies reveals serious lacunae in the form of community awareness and participation in these policies to the extent, that is essential to reach the target parameters of National Health Policy 2017 or Millennium Development Goals. Provisional welfarism has a limitation, and acknowledging that, incentive-based model of competence building among the population at large is the need of the day. Competency Based Health Assurance scheme envisions to take a step in this aspect, which may in the days to come be the deciding factor to propel the utilization of Publicly Financed Health Insurance schemes among the population at large, vis a vis empowering them to adopt healthy life styles for themselves.

Introduction:

The National Health Policy 2017 has been into force for more than three years now. Compared to the previous policy, reduction in Infant and Maternal Mortality rates, along with increase in the non-communicable disease burden have led to a paradigm shift in this current health policy of the country. The emergence of private healthcare sector as a robust stakeholder following the economic revolution in 1991 has become a handy tool, worth enough for the Government to exploit in it's venture of implementation of public health policies. Evolving interests of the NGOs and changes in the Corporate Social Responsibility (CSR) parameters are another potential area wherefrom the

Associate Professor Anesthesia, Burdwan Medical College, Burdwan, West Bengal Email : sumanta.gm@gmail.com

Government can take advantage for the interest of the public at large. Being a welfare state, implementation of provisions of Part IV of the Constitution of India (COI), becomes a compelling responsibility of every sensible Government so as to deliver justice, social, economic & political towards its citizenry.

The Ayushman Bharat (PMJAY) is a definitive step in this direction to ensure Availability and Accessibility of Quality health care in an Affordable manner for almost 40% of the country's population, respecting the visionary proclamations of UN Committee on Economic, Social and Cultural Rights through their General Comment on the Right to Health in 2000. However, in it's zeal to win the hearts of the electorate, the Government have raised their "legitimate expectations", but never dared to induce them towards performance of their common minimum duties that can fuel a remarkable acceleration in achieving the target attributes set by the Government, in order to accomplish the Millennium Development Goals (MDG) in time. Three of the MDG are directly related to Health, Maternal and child care & communicable diseases including Malaria, Tuberculosis and HIV/AIDS. As this article is being prepared, we can very well foresee that COVID will be the fourth and perhaps the most significant inclusion in this MDGs to be achieved. However, the pace and efficiency, with which these MDGs were thought to have progressed, have failed miserably in India and most of the Asian nations. The cause for such inadequacies cannot be simplistically delegated upon the Government and it's inefficiencies alone; rather, critical introspection is the need of the hour both on the part of the service providers as well as the consumers, the common people.

The Response and the Responsibilities of the Citizenry:

Most of the states that have adopted Ayushman Bharat are said to have been doing well ever since its inception. In 2017-18, insurers covered around 36 Crore individuals across all government schemes for health insurance. Since the inception of PMJAY in September 2018, thirty-two states and UTs (union territories) signed up for the scheme in the first year. This was an excellent beginning. However, present enrolment in PMJAY stands at around 10 Crore, one-fifth of the overall target. This is primarily driven by slow enrolment in larger states – Gujarat, Uttar Pradesh, and Maharashtra. Such states have covered only 35 per cent of the eligible families. The scheme was able to enrol 18,236 hospitals. Of these, 9,665 were private hospitals. In fact, of all the treatments served, 62 per cent of the expenditure was incurred in private hospitals. Around 46.5 lakh individuals availed treatment, with an average hospitalization cost of Rs 16,107. The average spends in a private sector hospital for the scheme was higher, at around Rs 18,801.

However, the story is not so glorious when we look at Chhattisgarh, having highest enrolment around 78% families. A study conducted by Samir Garg revealed, "enrolment under PMJAY or other PFHI schemes did not increase utilisation of hospital-care in Chhattisgarh. Out of Pocket Expenditure (OOPE) and incidence of Catastrophic Health Expenditure did not decrease with enrolment under PMJAY or other PFHI schemes. The size of OOPE was significantly greater for utilisation in private sector, irrespective of enrolment under PMJAY." The author concluded, "PMJAY provided substantially larger vertical cover than earlier PFHI schemes in India but it has not been able to improve access or financial protection so far in the state".

This brings us to the conjecture that even if the Government succeeds in achieving it's target enrolment of 50 crores population, will it truly enhance the rate of achieving the targets envisioned in NHP 2017 0r those of MDGs by 2025? A closer look at the seven priority areas of intervention in NHP 2017 reveals that successful implementation of NHP2017 requires active and committed participation from the common people as well. The Swachh Bharat Abhiyan, Balanced, healthy diets

and regular exercises, Addressing tobacco, alcohol and substance abuse, Yatri Suraksha - preventing deaths due to rail and road traffic accidents, Nirbhaya Nari -action against gender violence, Reduced stress and improved safety in the work place, Reducing indoor and outdoor air pollution, almost all are maximally dependent on the consumer's attitude towards the services provided so as to make a practically visible change in the outcome.

This is a truly herculean task for any Government and this requires a coordinated endeavour not only from the efficient bureaucracy, but also commitment of the stakeholders like insurance companies and private healthcare sector, and active participation of the recipient of these services.

Herein, we can think of exploiting the public image and relationship building capacity of the dedicated NGOs. Adequate liaison building through communication and mediation between the stakeholders and service consumers can be best accomplished by such organizations.

Competency Based Health Assurance:

Detailed study of the targets of NHP 2017 and MDGs reveal that mere provision of a facility or a logistic support on the part of the government are not enough to motivate the people at large to adopt healthy life style practices that would prevent both communicable and non-communicable diseases. This is glaringly evident in this pandemic era, when people are still reluctant to use their masks appropriately even. This needs behavioural modification at the larger scale. Incentive based behavioural modification is a well-established methodology in the management literature. This project envisages to exploit this theory in a larger domain [2].

The National Health Policy 2017 provides clearer directions regarding the role of state from being a service provider to overseeing the functioning of stakeholders with a thrust on strengthening the public-private collaboration in the sector. The policy also proposes an ambitious agenda of establishing institutions to cope up with the transition from welfarism to market economies. However, this capping of INR 5 lakhs (US$ 7000) per family may not be sufficient to cater all the needs of the present-day healthcare costs, more so in the private healthcare sectors. This has already been highlighted by Garg S et al, in their paper on Chhattisgarh [1].

This project aims to open up an opportunity for those families who wish to avail a larger sum of assurance, over and above the PMJAY. A higher sum assured without extra cost may be a welcoming offer for many consumers who have already availed the benefits of PMJAY. However, this extra benefit needs some contribution on the part of the consumers as well. Below are the set of GOALS that needs to be fulfilled by the consumers to be eligible to get enrolled for this added benefit. If one is competent, he becomes eligible for the benefit, and to be competent, one has to fulfil the below mentioned goals. The goals are set keeping in view, the target parameters of NHP 2017 and MDGs. The perception is, in their effort to avail the extra benefits, the people will be encouraged to achieve these criteria set before, and in their active involvement to achieve them, the hitherto staggering parameters would gain the necessary momentum, thereby increasing the chances of timely achievement of NHP 2017 and MDG targets.

Goals:

- Number of smokers in the family=0
- Antenatal care attendance=100%
- Immunization of children=100%
- Female Literacy rate= 60%
- Smoke less cooking =100%
- Gender based violence =0%
- Usage of indoor lavatory=100%
- School enrolment of children below 14=100%
- Access to health information and education including reproductive health for female population= 100%
- Prevalence of communicable disease like HIV

/AIDS & STD among migrant workers in the family <25%(Those with above disease 90% diagnosed,90%treated,90% virus free)

- Methods to preserve water within the house hold atleast 01
- Methods to develop environmental greenery: atleast 01 (tree plantation)

Those families which fulfil the above criteria will be eligible for a health insurance over and above the Ayushman Bharat scheme for a fixed amount per family[3].

Specific disease related insurance schemes can also be thought of e.g. diabetes, carcinoma, congenital defects or palliative care including dementia support care.

The scheme will be collaboration between the four parties – the NGO, the State and the private healthcare sector, the insurance company, and the individual family.

The objective is to encourage health related practices among the Indian population through incentive-based behaviour development program. The ultimate goal is to buttress the efforts of the government towards achieving the millennium development goals (MDG) which needs a serious boosting.

The long-term benefit is awareness building, induction of healthy behaviour, environmental protection, water conservation and last but not the least, attainment of target parameters of NHP 2017 & Millennium Development Goals in the entire process.

The other stake holders also have a larger fulfilment of their interests. The private health care sector gets higher capping of the services provided for; the insurance company gets larger opportunity to expand their policies, either through negotiation with the government or through the private sector hospitals directly; the NGO gets the opportunity to expand their domain of public communication and increase their visibility; and last but not the least, the consumer, through achievement of few targets, that themselves are beneficial for their health in the long run, gets assurance of a much larger health insurance which otherwise would not have been ever possible for them to dream even.

Discussion:

Being a welfare state, it is the responsibility of the state to abide by the directive principles of state policy as depicted in the part IV of Constitution. In the said perspective, provision of health insurance through Ayushman Bharat is a commendable job indeed, but just providing the platter has not been enough to bring a visible change in the public health status of our country in a significant manner.

Most of the Publicly Funded Health Insurance Schemes (RSBY) have been functioning for more than a decade, but it's limited capping at meagre INR 30000 (US$ 470), have failed to provide the desired financial protection for the most of the consumers. Out of Pocket Expenditure has been consistently on the rise, driving almost 30-40 million Indians below the poverty line every year. Even after one year of functioning of PMJAY, and almost 78% enrolment, the sates like Chhattisgarh shows dismal statistical figures regarding effectiveness of the policy in addressing the targets of NHP 2017 and MDGs as effectively as envisioned. The missing link in this conjecture might be the lack of commitment on the consumers towards their responsibilities while availing the benefits of public health care facilities, together with inadequacy of awareness campaign towards the same.

The frugal measure of responsibility that is expected from the commoners in our country is something of utopian philosophy. Our mass is not habituated to train themselves to behave like the Japanese, neither, they are as indifferent as most of the affluent nations as well. Like everything else, our citizenry needs an impetus, a booster to make them do something. Any incentive is well appreciated, particularly among the young generation, as evidenced by their zeal to accumulate and redeem points through their daily grocery marketing even. With this social psyche in the background, this

program envisages to exploit this potential of the commoner through incentive-based scheme, where, the criteria of eligibility are the above-mentioned goals to be fulfilled.

The goals selected are not exhaustive, neither fixed. They can be modified on the basis of the local need-based approaches depending upon the geographical and socio-cultural milieu. This is just an initial example whereby the policy has to be devised, keeping in mind, the interests of all the stakeholders in the arena [4].

The insurance company, the NGOs, the State government, the Central Government, all have their specific areas of interest, and precise roles to play. This project is a novel theorization of that EXTRA thing that can be done to boost up the moral of the people, without their conscious realization, and trying to bring in a specific change in their behavioural attitude, which will play a significant role, in order to accomplish the larger goals of the governmental policies in the entire public health sector.

The impetus in the form of upgradation to the next level of insurance coverage, is quite a lucrative offer that will induce many to accomplish the set targets through behaviour modification and lifestyle changes which is in fact, not a huge task for anybody. Only, that they don't get the motivation to bring in that on their own. This project is just that little EXTRA boosting that they are subconsciously waiting for.

The schemes, proportionality of participation, the reasonableness of the stakes conferred upon, all needs to be streamlined before introduction of this project, but, in trying to be too much objective, we must not forget that the primary principle of welfare state is to provide for with all those that a dignified life requires to be led, and our project should always uphold this motto as the preliminary criteria, before embarking upon the EXTRA involvement of these people at large. A weak, disabled, or otherwise incapable should be given the necessary exemptions, so that, the people can realize the actual vision of the Government, not to force them to exploitation, but to empower themselves to achieve the targets of healthy living lifestyle and wellbeing [5].

Conclusion:

Public health sector has been suffering the wrath of compromise and inadequacies ever since the Independence of this country. Multiple judicial pronouncements and activism had to be instrumental in forcing the governments time and again, for implementation of the responsibilities bestowed upon them through the Directive Principles of State Policy in the Constitution of India. National Health Policy 2017 and PMJAY 2018 have been two landmark projects of the Indian Government in order to streamline the public health care system through intersectoral collaboration, acting as a facilitator rather than the controller, and responding to the contemporary concepts of market economy in a reasonable manner, notwithstanding its responsibilities as a protector, provider, entrepreneur, economic controller and arbiter of its citizenry in a welfare state. However, the results of such remarkable endeavours are not so encouraging as of yet. Critical analysis of the policies reveals serious lacunae in the form of community awareness and participation in these policies to the extent, that is essential to reach the target parameters of National Health Policy 2017 or Millennium Development Goals. Provisional welfarism has a limitation, and acknowledging that, incentive-based model of competence building among the population at large is the need of the day. Competency Based Health Assurance scheme envisions to take a step in this aspect, which may in the days to come be the deciding factor to propel the utilization of Publicly Financed Health Insurance schemes among the population at large, vis a vis empowering them to adopt healthy life styles for themselves.

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Contribution in JIMLEA

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Medicolegal News

Compiled by : Dr. Santosh Pande

Surgery With Blank Consent Form: Hospital Told To Pay Rs 1 Lakh

Ahmedabad: Observing that the consent form was completely blank, and the hospital did not provide the medical case papers to the patient's family until being sued, the Gujarat State Consumer Disputes Redressal Commission has held the facility guilty of negligence and deficiency in service.

Thus, the consumer court has directed the Ahmedabad-based hospital to pay Rs 1 lakh to the complainant, the widow of a patient, who was operated upon at the hospital for the removal of a tumour from his abdomen.

The case goes back to 2006, when the patient hailing from Jaskagam near Dhandhuka town, was taken to the hospital in February 2006 for an operation to remove a tumor. However, the tumour could not be removed and the treating hospital discharged the patient after a few days for further treatment of cancer. The patient, unfortunately, died in April that year.

Alleging medical negligence and deficiency in service, the widow of the patient approached the Consumer Dispute Redressal Forum, Ahmedabad (rural). The complainant alleged that the surgery was performed without conducting Prothrombin Time test, and the tumour was not removed from the abdomen even after incision.

It was further alleged, on the behalf of the complainant, that the treating hospital didn't obtain consent for the surgery from the patient or his relatives and didn't provide the family with the medical case papers as well. Contending that as per the rules, the hospital is liable to provide the patient with the medical case papers within 72 hours, the complainant in her plea before the Consumer court sought a compensation of Rs 10 lakh from the treating hospital.

As the district Forum dismissed the complaint, the complainant approached the State Commission afterwards. Recently, the judgment of the State Commission came, and the Commission exonerated the doctor of the charges of medical negligence as the Commission held that the treating doctor had performed his duty and exercised an ordinary degree of professional skill and competence.

The counsel appearing for the complainant, advocate V M Gamara had informed that although the Commission dismissed the medical negligence on the part of the treating doctor, it noted that the consent form was completely blank, meaning informed consent was not obtained from the patient or his family. As per the Commission, this amounts to medical negligence.

Further, the Commission also observed that the hospital provided the patient's family with the medical case papers only in 2008 after being sued by the Complainant. Noting that this is against the rule of providing case papers within 72hours, the consumer court ruled that it is a deficiency in service on the part of the treating hospital.

Thus, holding the Ahmedabad-based treating hospital guilty of medical negligence and deficiency in service, the State commission directed the hospital to pay Rs 1 lakh as compensation to the complainant. The hospital has been further asked to pay Rs 10,000 to the complainant for incurring the legal expenditure.

Ref. : *https://medicaldialogues.in/news/health/medico-legal/surgery-with-blank-consent-form-hospital-told-to-pay-rs-1-lakh-79799 Accessed on 24/07/2021*

Violation Of MCI Code Of Ethics: Rajasthan Medical Council Suspends License Of 2 Doctors

Jaipur: Taking stringent action against the doctors for violation of the MCI code of ethics, the Rajasthan Medical Council has recently suspended the license of two associate professors attached to Government medical colleges in two different cases.

One case concerns exaggeration by the faculty in qualifications and credentials, while the other case concerns the diverting of the patient from a government facility to a private hospital run by the doctor.

Case 1: Wrong degree, Exaggerated journal contribution claims

Practicing Anesthetist & President IMLEA, Amravati Branch E mail:drpandesr@gmail.com

The case of the first doctor concerns the usage of the wrong degree on her letterhead as well as exaggerating the claims of contributions that the doctor has made to medical journals. The doctor is reportedly associated with the Ajmer based JLN Medical College.

According to a recent report by the Times of India, the doctor had mentioned in her annual confidential report (ACR) that she had contributed to 177 medical journals, whereas in reality, she had contributed only to 55 medical journals. Further, on the letterhead, she had mentioned having a PhD in cardio, which is actually not a degree or qualification. She has been suspended for a period of six months. While commenting on the issue, an official from the medical council has informed the daily that such information on the letterhead was misleading.

Case 2: Shifting of the patient from government hospital to own private facility

The second case concerns a doctor who had allegedly transferred a patient from the government medical college hospital to his own private hospital. The doctor is attached to SMS medical college as an Associate Professor. The council took action against him based on a complaint filed by the husband of a patient who had died after being transferred from the SMS hospital to a private hospital run by the doctor. She was treated for 15 days at the private facility, after which her situation worsened and she was again shifted to the Government hospital.

Following the death of the patient back in 2017, her husband filed a complaint against the doctor. Speaking to the daily, State Medical Council official informed, "The incident happened in 2017, but the hearing of the case is completed now and we have taken the decision for suspension of his license."

The decision to these effects were taken by a panel of the ethical committee of Rajasthan Medical Council comprising Dr. Ish Munjal, Dr. Jagmohan Mathur, Dr. Srikant, and Dr. Deepak Sharma who have now suspended the registration of the doctors.

"They will not be allowed to practice medicine for the tenure of suspension of their licenses," the official told.

Ref.: *https://medicaldialogues.in/news/health/doctors/violation-of-mci-code-of-ethics-rajasthan-medical-council-suspends-license-of-2-doctors-80056?in ...Accessed on 24/07/2021*

Wheelchair Fall: Mumbai Hospital Directed To Pay Rs 3.5 Lakh Compensation For Injury In Hospital

New Delhi: Upholding the decision of the State Commission, the National Consumer Disputes Redressal Commission (NCDRC) has recently directed a Mumbai-based multi-speciality PD Hinduja National Hospital Hospital to pay Rs. 3.51 lakh as compensation to a patient who suffered a 'head-on fall' from the wheelchair while rashly and negligently wheeled from the hospital corridor.

Dismissing the revision petition filed by the Hospital, Dr. S.M. Kantikar, Presiding member of NCDRC held that injuries arising out of a wheelchair in a medical setting, purportedly due to negligence of staff, does not fall within the purview of medical negligence. However, it observed that the patient underwent mental agony and physical trauma and the quantum of award made by the State Commission was just.

As a word of caution, the top consumer court advised the Hospital authority to make systemic improvement in their administration and their grievance redressal mechanism to ensure the patient's safety and to maintain good Doctor-Patient relationship

The case goes back to 2012 when the complainant patient had visited the treating hospital for a follow-up check-up after spinal surgery. The complainant alleged that she was very rashly and negligently wheeled from the hospital corridor, on the ramp by an unidentified security guard without putting on the seat belt. This resulted in an accident and she suffered 'head on fall' from the wheelchair and sustained fracture of left (ankle) lower end fibular tip.

It was further alleged by the Complainant that the first-aid was not given to her, and she had to stand in queue for payment of X-Ray charges. When the treating hospital was made aware of the incident the authorities willfully avoided informing the police about such serious accident in their premises.

Alleging gross negligence & deficiency in service from the supportive staff at the hospital the Complainant had approached the District Forum and also filed an FIR in the concerned police station.

On the other hand, the treating hospital had claimed that a junior doctor at the hospital had immediately attended the patient after the fall and provisional diagnosis mentioned as undisplaced fracture of lower end of the left tibia. After the treating doctor examined the patient and ruled out any fracture or any dislocation of left ankle joint, a Sugar tong splint was given which was to be removed after 5 days and an Air Cast splint was advised to be worn after 5 days.

Claiming that the patient was treated as per standards, the hospital prayed for the dismissal of the complaint. The District Forum partly allowed the complaint and directed the hospital to pay Rs. 1,00,000/- as compensation and Rs. 10,000/- towards the cost of legal proceedings to the Complainant. When the hospital approached the State Commission, challenging the District Forum's order, State Commission dismissed the appeal with costs of Rs. 25,000/-on the hospital and modified the earlier order of the District Forum. By the judgment of the State Commission, the hospital was asked to pay Rs 3,51,000/- to the Complainant within one month from the date of the order failing which, the amount was to carry interest at the rate of 9% per annum.

Unhappy with the State Commission, the hospital finally approached NCDRC, which related the case to deficiency in service and an act of omission from the hospital staff.

After hearing the contentions of both the parties, the top consumer court noted that the State Commission had recorded the concurrent finding of fact and passed a well-appraised reasoned Order.

Referring to several judgments by the Supreme Court the NCDRC opined that the case doesn't contain any of the ingredients of medical negligence as laid down by the Apex Court.

Although the top consumer court opined that the case doesn't fall strictly under medical negligence, it mentioned, "Wheelchairs are usually thought of a medical device that is meant to help those who are injured or have physical challenges; they can also be a source of injury when not properly used. Most wheelchair injuries that happen in a medical setting due to the negligence of medical staff and such could be easily prevented by hospital or nursing home."

"As a word of caution, in my view, the Hospital authority should make systemic improvement in their administration and their grievance redressal mechanism to ensure the patient's safety and to maintain good Doctor-Patient relationship," further added the Commission. Dismissing the revision petition by the hospital, the Commission noted, "Having regard to the fact that patient underwent mental agony and physical trauma and the quantum of award made by the State Commission appears just and equitable in the facts of the case."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/wheelchair-fall-mumbai-hospital-directed-to-pay-rs-35-lakh-compensation-for-injury-in-hospit...Accessed on 24/07/2021*

Decision To Perform Emergency Caesarian Was Correct: Anaesthetist, Hospital Absolved Of Medical Negligence

New Delhi: Observing that the decision taken by the doctor was right of conducting an emergency Caesarian operation on the patient, who in the advanced stage of labour, the National Consumer Disputes Redressal Commission (NCDRC) has exonerated her and the hospital against the charges of medical negligence.

According to hospital records, the concerned doctor was an anaesthetist and she had not performed the Caesarian operation. On perusal of the Operation theatre (OT) register and operative notes, the bench noted that a Surgeon who was regularly performing surgeries in the hospital performed the Caesarian operation under spinal anaesthesia and a baby was delivered.

The top consumer court noted that the main allegation of the Complainant was that the cause of death of his wife was either due to spinal shock because of excessive anaesthesia or mismanagement while applying anaesthesia or excessive bleeding at the time of delivery which the doctor had failed to control. Although the Commission opined that the first nursing home could have directly referred the patient to PGIMS, rather than referring to the treating hospital, it further noted that the doctor dealt with the medical emergency with due medical care.

"It was an emergency managed by the OP-2 doctor (anaesthetist) as per the standard reasonable practice. The duty of treating doctor is to decide the

method of treatment depending upon the condition of the patients and the circumstances of each case, thus it cannot be construed as medical negligence," noted the judgment by Dr S.M.Kantikar, presiding member of the NCDRC.

The case concerns the complainant's wife, who during her pregnancy, was under regular observation in Civil Hospital, Kalka. However, after the labour pain started she was referred to the hospital, and there, the surgeon performed a cesarean section upon her. Post-operation, after giving birth to a female baby, the patient became critical and unconscious. So, the treating hospital in Pinjore referred the patient to PGI Chandigarh. On the way to the hospital, the patient died. The death certificate issued by the hospital had mentioned that the patient had died due to Septicemia with labour pains.

Alleging medical negligence against the doctor and hospital, the complainant approached the District Forum, Kalkaand submitted that the patient was referred to PGI Chandigarh, without providing any medical attendant.

On the other hand, the doctor and hospital had denied negligence during delivery and submitted that when the patient was brought to the hospital, she had a 50% effaced cervix and with a fever of 102 0F. Her pulse rate and respiratory rate were also high. The doctor diagnosed it as septicemia and the treatment was started immediately to save the patient as well as the baby.
They have further informed that after taking due consent, the Caesarian operation had started. However, during the closure of the operative wound, the patient suffered hypotension and convulsion. The Patient was revived, but again she developed hypotension, which did not improve further despite treatment. So, for further management, the patient was referred to PGI Chandigarh in the hospital ambulance along with nurse, Ambu bag with O2 and IV lines.

Denying negligence on their part, the doctor and hospital had submitted before the Forum that despite resuscitative efforts, the patient couldn't be revived and was declared dead at 10.00 P.M.

After listening to both the parties, the District Forum had allowed the complaint and had ordered the doctor and the hospital to pay a lump sum compensation of Rs 5 lakh to the complainant. When the order of the District Forum was challenged before the State Commission, the Commission had upheld the previous order. So, the doctor and the hospital approached the NCDRC and filed a revision petition.

The Commission noted that at the time of admission the patient had a high grade fever and anemia. Further, looking at the medical records the Commission noted that the operation was not performed by the treating doctor, who was an anesthetist. In fact, another surgeon, regularly operating at the treating hospital had performed the Caesarian operation under spinal anesthesia. The medical records further revealed that the emergency was managed by the treating doctor as per standard reasonable practice.

Referring to the Supreme Court judgment in the case of Jacob Mathew v State of Punjab, the Commission mentioned that in this particular case, the Apex Court had stated that when faced with a medical emergency, the doctor always tries his best to redeem the patient out of his suffering. No sensible professional would intentionally commit an act or omission which would result in loss or injury to the patient, the Apex Court had held.

In that particular case, the Supreme Court had also held that "a mere deviation from normal professional practice is not necessarily evidence of negligence."

The commission pointed out that the instant case involved a patient in an advanced stage of labour and it was an emergency “The decision of the treating doctor was "correct to perform emergency Caesarian operation to save the life of patient and the foetus. Therefore, not referring the patient to PGIMS was neither act of omission nor negligence," noted the Commission.”

"It was an emergency managed by the OP-2 doctor (anaesthetist) as per the standard reasonable practice. The duty of treating doctor is to decide the method of treatment depending upon the condition of the patients and the circumstances of each case, thus it cannot be construed as medical negligence," stated the judgment by the Apex Consumer Court.
Further referring to the Supreme Court judgment in the case of Achutrao Haribhau Khodwa vs. State of Maharashtra & Ors, the Commission reminded that negligence cannot be attributed to a doctor so long as

he is performing his duties to the best of his ability and with due care and caution.

The Commission further noted that both the District and State Commission didn't observe any negligence on the part of the treating doctor but held the treating doctor and hospital liable because the patient was not referred to PGIMS.

Thus, setting aside the orders of the District and State Commission, the NCDRC dismissed the complaint and exonerated the treating doctor and the hospital.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/decision-to-perform-emergency-caesarian-operation-was-correct-anaethetist-hospital-absolv... Accessed on 21/08/2021*

Failure In Diagnosing Neck Femur Fracture: Top Consumer Court Directs St Stephens Hospital To Pay Rs 5 Lakh Compensation

New Delhi: Observing that the failure in diagnosis of fracture neck femur resulted in an unfavourable outcome for a patient, the National Consumer Disputes Redressal Commission has directed the Delhi-based St Stephen's hospital to pay Rs 5 lakh compensation, following the earlier order of the District Commission on the matter.

Setting aside the order of the State Commission, which had reduced the amount of compensation, the top consumer court took note of the fact that after the operation at the treating hospital, the complainant had to undergo surgery twice, which failed to permanently cure his physical condition. "Considering the loss of earning capacity and future prospects, in our view, the compensation of Rs.5.0 lac is just and fair," noted R.K Agarwal, President of NCDRC, and Dr. S.M. Kantikar (member).

The case concerned the patient who had suffered a road accident back in 2003 and sustained bodily injuries thereafter. After getting first-aid at a Government hospital, the patient was referred to the hospital where the treating doctor examined him and diagnosed him having a fracture of femur (thigh bone) on the right side.

Following this, the patient had undergone surgery and a rod was implanted from his loin to the thigh. During the follow-up treatment, a second doctor at the treating hospital examined the patient again and assured that it would take some more time for everything to get cured.

However, as the pain didn't get reduced and in May 2004, the complainant contacted another doctor who opined that there was a fracture of the loin bone, and advised the patient to approach the same hospital where he was first operated on.

Meanwhile, the family doctor of the complainant examined all the X-rays of the patient and opined that the fracture had occurred during the 1st operation in the Operation Theatre (OT) of the treating hospital. When the patient again approached the hospital, he was advised for bone grafting as there was an unsatisfactory union of bones, for which the complainant didn't agree.

Again the complainant came back to the hospital with the complaint of pain in right hip and thigh. The X-ray revealed displaced intra-capsular fracture of neck femur and he was advised to undergo osteosynthesis- a valgus osteotomy and fixation with angled blade plate.

Unable to bear the cost of another operation, the complainant approached a Government Hospital for further treatment.

Thereafter, alleging medical negligence against the treating hospital, the complainant approached the District Forum and claimed a total amount of Rs. 16,97,800/- as compensation. The patient contended that X-ray taken before the operation didn't show any intra capsular fracture of neck femur. However, the X-ray taken after surgery within 24 hours, clearly revealed the intra capsular fracture neck femur. Denying that the fracture of the loin bone had occurred during the surgery, the hospital submitted that the Complaint was false, misconceived and not maintainable. The hospital further submitted before the District Forum that the complainant was initially treated at a Government hospital, wherein the X-rays showed only fracture of femur shaft.After hearing the contentions of both the parties, the District Forum partly allowed the complaint and directed the hospital to pay Rs 5 lac to the complainant along with Rs 5,000 as cost of litigation.

Dissatisfied with the directions of the District Forum, the treating hospital reached the State Commission, which modified the quantum of

the award. The State Commission directed the hospital to pay a lump sum compensation of Rs. 2.5 lakh to the patient.Thereafter, challenging the order, both the parties filed two separate applications before the NCDRC. The top consumer court listened to all the contentions of both the parties and perused the material on record, the Medical Record and the X-ray films.

After browsing through the medical literature related to the case, the Commission noted, "As per the medical text; after stabilization of fracture of shaft femur due to stress iatrogenic fracture neck of femur may occur. Therefore, the presence of a sub-clinical occult fracture and failure to take necessary X-rays in external rotation of the shaft of femur may account for pre-operative mis-diagnosis."

Noting that the treating doctor had performed the operation for intramedullary nailing of shaft femur, the NCDRC bench observed, "However, failure to take appropriate X-rays with external rotation of the shaft of the femur to rule out the presence of a sub-clinical occult fracture, may account for pre-operative mis-diagnosis. The pre-operative CT scan of the femur neck for all such patients was to be done before intra-medullary nailing of shaft fracture, i.e. closed nailing. The CT scan was to be repeated after closed nailing to confirm the condition of the femoral neck, unless a fracture was seen on a plain film or during intra-operative fluoroscopy."

"Having regard to the settled law that an error of judgment/failure to make diagnosis of a complicated condition by itself does not amount to negligence, but it can be said that missing fracture neck femur which normally is missed in 50% cases, is an act of negligence," the judgment mentioned.

Taking note of the fact that in 1/3rd of cases of femoral neck fracture, the diagnosis is either delayed or missed, the Commission observed, "Thus, it is essential to carefully evaluate the femoral neck in all patients sustaining high-energy femoral shaft fractures. Although there are a number of different implant options available for management of this challenging injury, most authors recommend that priority be given to anatomic reduction and optimal stabilization of the femoral neck fracture because nonunion, malunion, or avascular necrosis of this injury is more difficult to treat successfully."

"It is therefore important to understand that, especially in polytraumatized patient, present with femoral shaft fracture, the highest level of suspiciousness must be maintained for the concomitant presence of an ipsilateral femoral neck fracture," added the Commission.

Later, going through the medical record of the case, the Commission noted, "the patient was evaluated with a pre-operative X-ray AP pelvis, which was negative. It was unclear whether a lateral view of the hip taken could have been more sensitive in detecting the femoral neck fracture. In our view the antero-posterior internal rotation hip X-ray if taken intra-operatively or immediately after the reduction of the femoral shaft fracture, could have helped in detecting the minimally displaced fracture of the femoral neck."

Noting that the complainant had established that the “delay/failure in diagnosis of fracture neck femur contributed to the unfavourable outcome," the Consumer Court ruled that "the treating doctor failed in the duty of care in the administration of treatment."

Referring to several judgments of the Apex Court which reiterated the principle of standard of care which is expected from a medical professional with a reasonable degree of skill and knowledge, the Commission disagreed with the view of the State Commission, which reduced the quantum of the compensation.

Upholding the judgment of the District Forum, the Commission noted, "It is to note that after the treatment, subsequently, the Complainant underwent operation twice in Hedgewar Sansthan at Delhi but his physical condition did not improve. The doctors informed him about no possibility of complete cure in the future. He was the sole earning member in the family. The Complainant had been suffering since the year 2003 and we are now in 2021. Considering the loss of earning capacity and future prospects, in our view, the compensation of Rs.5.0 lac is just and fair."

Thus, the top consumer court directed the treating hospital to pay compensation of Rs.5 lac with interest @ 6% per annum from the date of filing of the Complaint and Rs. 25,000/- towards the cost of litigation within 4 weeks date of order, failing

which the entire amount shall carry 10% interest till its realization.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/failure-in-diagnosing-neck-femur-fracture-top-consumer-court-directs-st-stephens-hospital-to... Accessed on 21/08/2021*

Madras High Court Directs Rs 5 Lakh Compensation On Death Due To Non-Availability Of Ambulance

Madurai: Although the Madurai bench of Madras High Court didn't find any negligence on the part of the treating doctor, the Court has recently directed the State Government to pay Rs 5 lakh compensation from the Corpus fund to a man who lost his life after childbirth due to the non-availability of an ambulance at the Primary Health Centre (PHC).

The High Court bench comprising of Justice Justice N. Anand Venkatesh observed that the non-availability of the ambulance caused delay in shifting the patient from the PHC to a better medical facility and it ultimately resulted in the loss of 'golden hour', the time between life and death.

In the judgment dated 29.06.2021, the single-judge bench of the High Court held that "even though this Court does not find any negligence on the part of the fourth respondent insofar as the treatment that was given to the petitioner's wife, there was definitely a delay in shifting the petitioner's wife from the Primary Health Centre to the Medical College, Asaripallam. Since the petitioner's wife was suffering from heavy bleeding, this delay had ultimately proved to be fatal resulting in her death."

After perusing the facts and materials related to the case, the HC bench opined that the petitioner fulfils the criteria of Sub Clause II of Clause 4(G) of the G.O.Ms.No.395, dated 04.09.2018, which was brought into force by the Government by creating a Corpus fund. "Hence, the petitioner is entitled to be paid compensation under this Government Order to the tune of Rs.5,00,000/- (Rupees Five Lakhs Only)," ruled the bench further directing the Government to make the payment within a period of eight weeks from the date of receipt of a copy of the order.

The case concerned the petitioner's deceased wife who was taken to the Primary Health Centre back in 2012 for the delivery of her baby. The petitioner alleged that after delivery, there was excessive bleeding suffered by his wife.

Even though the situation was critical, the treating doctor in spite of attending the wife of the petitioner and administering her with necessary drugs, found that the victim required a blood transfusion and hence, recommended for shifting the patient to Medical College, Asaripallam, alleged the petitioner. As there was no ambulance available at the PHC, the Staff nurse had called 108 ambulance which had arrived after 30 minutes and finally when the patient had reached the Medical College, she was declared as dead due to 'postpartum haemorrhage'.

The petitioner alleged that he lost his wife only due to the delay caused due to the non-availability of the ambulance and filed the petition under Article 226 of the Constitution of India, seeking a compensation of Rs 25 lakhs for the loss.

Both the District Medical Officer and the treating doctor had denied any kind of negligence in treatment. The District Medical Officer had also pointed out that Postpartum Haemorrhage was a common cause for maternal death after the delivery and in India it accounts for almost 38% of maternal death.

The treating doctor had further submitted that after observing the patient was bleeding more than normal, he had immediately administered all the necessary drugs and offered the patient the necessary first aid as well. However, in order to avoid any unfortunate incident, he had recommended shifting the patient to a better medical facility and the process was taken care of immediately as well. He further submitted that the patient was stable at the time of shifting the treating doctor had denied any negligence on his part.

During the hearing, the Court on 29.04.2021 had taken note of the submission made by the counsel for the petitioner regarding the Government Order dated 04.09.2018. In fact, the counsel for the petitioner pointed out that earlier in a different case, the High Court in the order dated 01.02.2021, had granted a compensation of Rs 5 lakh on the basis of this Government order.

Medical Dialogues had also reported about that case where the Madras High Court had held that in case of a government hospital, even despite no medical negligence, if there is an injury, then the government should pay compensation.

Although in that case, the Court had not found any medical negligence on the part of the doctors and anaesthetist of Government Head Hospital, the Madurai Bench of Madras High Court had stated that since the 8-year-old patient had gone to the Government hospital for treatment, the Government should pay Rs. 5 lakh as "ex-gratia" to the deceased girl's family belonging to a notified scheduled caste community from the corpus fund of the Government.

Taking note of this submission on the part of the counsel for the petitioner, the High Court bench had observed on 29.04.2021, "If the facts of the present case is also confined to the Government Order, there is no requirement for this Court to go into the issue of negligence. It will be possible to give necessary directions based on the Government Order and the earlier order passed by this Court."However, the counsel for the Government on the last date of hearing had submitted that the petitioner couldn't be given compensation as per G.O.Ms.No.395, Health and Family Welfare (H1) Department, dated 04.09.2018, since the death of the petitioner's wife was not caused due to negligence.

After perusing the facts and materials related to the case carefully, the single-judge bench of Madras High Court noted that in this unfortunate case the petitioner had lost his life due to excessive bleeding after childbirth. Agreeing with the submission made by the District Medical officer, the Court stated that the condition suffered by the petitioner's wife (postpartum haemorrhage) was not uncommon but unfortunate.

Considering the submission made by the treating doctor, the Court also agreed that the doctor had administered necessary drugs as a first aid to the petitioner's wife and attempts were made to bring the situation under control. However, as the bleeding didn't stop the doctor advised to shift the patient to a better facility.

"This is where the entire problem started. There was no ambulance available at the Primary Health Centre and the Staff Nurse belonging to the Primary Health Centre was desperately attempting to get an ambulance by calling 108 and the ambulance reached the Primary Health Centre only around 05.45 a.m. In this process nearly 30 minutes of precious time was lost," observed the Court. "It is clear from the above that there was a delay in shifting the deceased from the Primary Health Centre to the Medical College, Asaripallam. When it comes to saving life, every second counts and delay by even few minutes can cause the death of a person. Therefore, when it comes to medical emergency, delay can never be condoned like how leniently we condone in Courts," the Court further noted.

Referring to a Supreme Court judgment in the case of P.B.Khet Mazdoor Samity Vs. State of West Bengal, the High Court bench mentioned that Primary Health Centres are expected to possess an ambulance to meet an emergency.

In this context, the Court further opined, "Every Primary Health Centre is supposed to have an ambulance readily available to shift patients in case of emergency. It is an admitted case that the Primary Health Centre was regularly dealing with delivery cases and they have to expect an emergency at any time and they cannot afford to run a Centre without ambulance."

Finally, the Court observed, "In view of the above, even though this Court does not find any negligence on the part of the fourth respondent insofar as the treatment that was given to the petitioner's wife, there was definitely a delay in shifting the petitioner's wife from the Primary Health Centre to the Medical College, Asaripallam. Since the petitioner's wife was suffering from heavy bleeding, this delay had ultimately proved to be fatal resulting in her death. In Medical Parlance, it is referred to as golden hour." Thus the Court directed the Government to pay Rs 5 lakh as compensation to the petitioner from the Corpus fund noting that the case of the petitioner will fall within the requirements of Sub Clause II of Clause 4(G). "Hence, the petitioner is entitled to be paid compensation under this Government Order to the tune of Rs.5,00,000/- (Rupees Five Lakhs Only)," ruled the Court directing the State to make the payment within eight weeks.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/madras-high-court-directs-rs-5-lakh-compensation-on-death-due-to-non-availability-of-ambul... Accessed on 21/08/2021*

Delay In Surgery:Consumer Court Directs Hospital To Pay Rs 10 Lakh For Death Of Patient

New Delhi: Noting delay in surgery by the doctors at

a city-based Northern Railway Central Hospital, the Delhi State Consumer Disputes Redressal Commission has recently directed the hospital to compensate for the death of a patient who was diagnosed with "Liver Abscess ruptured into peritoneum, septicaemic, ac. Renal failure."

The State Consumer Court noted, "Despite such serious condition of the patient, the Doctors kept on delaying surgery which was so vital so as to save the life of the patient" and directed the Railway Hospital to pay Rs 10 lakhs with interest at the rate of 5% from the date of the alleged negligence within a period of two months.

Dr. Justice Sangita Dhingra Sehgal, President of the State Commission observed in this context that "Awarding of cost would surely serve the purpose of bringing about a qualitative change in the attitude of the hospitals for providing service to the human beings as human beings. Human touch is necessary; that is their code of conduct; that is their duty and that is what is required to be implemented more so when personal liberty is guaranteed under Article 21 of the Constitution."

The case goes back to 2011, when the wife of the Complainant was having pain in her abdomen. Upon investigations done in Aligarh, it was found that the patient has an abscess and accordingly the doctors in Aligarh advised taking the patient to a better facilitated hospital. Consequently, the complainant took his wife to Northern Railway Hospital and the treating doctor in the Emergency ward after examining the patient referred her to the surgery department.

Thereafter, the doctor at the surgery department prescribed some tests and recommended admitting the patient to the medical ward. The doctor in the medical ward examined the patient again and opined it to be a case of "Liver Abscess ruptured into peritoneum, septicaemic, ac. Renal failure..."

The complainant had alleged before the Commission that despite such a serious condition of the patient, the doctors kept on delaying the surgery which was essential for saving the life of the patient. In fact, the patient remained unattended for an entire day, he said. During this period, the patient was left in the care of the nurses and it was only late in the evening of the next day that the treating doctor, upon finding the condition of the patient to be grievous, decided to operate on her.

As it was not possible at that time to conduct fresh investigations, the operation was conducted on the basis of the tests done in Aligarh.

The Complainant further alleged that the hospital lacked adequate facilities to treat the patient and also the surgeon who conducted the operation was not competent enough. Post-operation, the patient was shifted to the ICU and was put on a ventilator. However, the patient couldn't survive and died on March 29, 2011.

Alleging delayed treatment, lack of competence on the part of the treating doctor and lack of reasonable care and caution during treatment, the complainant approached the State Consumer Court and sought Rs 30 lakhs as compensation for negligent and incorrect treatment, Rs 10 lakhs for mental torture and harassment, and Rs 5 lakhs as costs of litigation.

The hospital, on the other hand, denied all these allegations and submitted that the patient was provided with the best available care possible. Besides, the hospital urged that the complaint didn't have any merit on the technical ground as well because Northern Railway Central Hospital, New Delhi was a Government hospital and the complainant was not charged a single penny for the treatment of his wife. Therefore, when the hospital has done free treatment, the service rendered by the Government Hospital is outside the purview of the expression 'service' as defined under Section 2(1)(o) of the Act, contended the hospital authorities.

After perusing the details of the case and going through the contentions of both the parties, the State Commission referred to several judgments to define negligence on the part of a treating doctor or hospital. The Commission placed reliance on Black's law Dictionary, Hulsbury's Law of England, Supreme Court judgment in Jacob Matthew's case and in Bolam versus Friern Hospital Management Committee, Arun Kumar Manglik Vs. Chirayu Health And Medicare Private Limited & Anr., 2019 etc.

Referring to all these previous judgments and textbook definitions, the Consumer Court noted, "What is expected from the medical practitioner is to take due care and caution while giving treatment as per the established medical jurisprudence avoiding

delay. In other words, if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art, no question of deficiency would arise."

In the context of the present case, the Commission noted that the argument of the Complainant was supported by evidence that the patient after being brought to the Railway Hospital on March 18, was kept in the medical ward, ignoring her deteriorating conditions whereas she was required to be taken to the surgery ward.

The Commission also observed that the treating doctor of the surgery department had wasted good time, examined the patient and directed that she be admitted in the medical ward ignoring the condition of the patient. At this outset that Commission also referred to the diagnosis by the medical ward, i.e. "Case of 'liver abscess ruptured into peritoneum, septicaemic, ac. renal failure..."

"Despite such serious condition of the patient, the Doctors kept on delaying surgery which was so vital so as to save the life of the patient. The patient was left unattended in such grievous condition and no Doctor attended to her for the entire evening of 18 March till 19 th afternoon. The patient during that period was left totally at the hands of the nurses only. No tangible or cogent evidence has been led by the Ops controverting this serious allegation except to the extent that the patient was looked after nicely and properly," noted the Commission after perusing the facts related to the case.

Further referring to the argument of the hospital that they had failed to evaluate the ailment despite undertaking multiple tests, the Commission noted that the counsel representing the hospital could not establish even remotely either from the pleadings or from the evidence that the hospital had done the spade work as was expected of them in due discharge of their duty as treating doctors. "Their submission that due and proper care was exercised cannot be accepted for their inability to detect the ailment and commence the treatment. Timely detection and the treatment could have helped the patient and to the family," noted the Commission.

Further referring to the contention of the hospital that the treatment was free of cost, the Commission observed that a previous NCDRC order has overruled the contention and the top consumer court had also held earlier that "Non-exercise of reasonable caution in treatment amounts to negligence."

Thus, allowing the complaint, the Delhi State Consumer Court, after considering the circumstances of the case, the age of the patient and other necessary and essential factors, decided the amount of compensation and observed, "It would be just and reasonable to award compensation of Rs. 10 Lakhs (Rupees Ten Lakhs) with interest at the rate of 5% from the date when the cause of action arose and negligence was admittedly done till the realisation of the amount, to the complainant for the suffering, mental pain and agony caused."

"The amount so awarded be paid by the OP hospitals being liable, within a period of two months from the date of receipt of the certified copy of this order. Awarding of cost would surely serve the purpose of bringing about a qualitative change in the attitude of the hospitals for providing service to the human beings as human beings. Human touch is necessary that is their code of conduct; that is their duty and that is what is required to be implemented more so when personal liberty is guaranteed under Article 21 of the Constitution," further read the order of the Commission.

Ref.: *https://medicaldialogues.in/news/ health/ medico-legal/delay -in-surgery-consumer-court-directs-hospital-to-pay-rs-10-lakh-for-death-of-patient-81117 Accessed on 25/08/2021*

INDIAN MEDICO-LEGAL & ETHICS ASSOCIATION

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LIFE MEMBERSHIP FORM

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(Surname) (First name) (Middle name)

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Address for Correspondence: _____

_____

Telephone No.s : Resi. : _____ Hosp. : _____ Other : _____

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_____ _____
Name, membership No. & signature of proposer Name, membership No. & signature of seconder :

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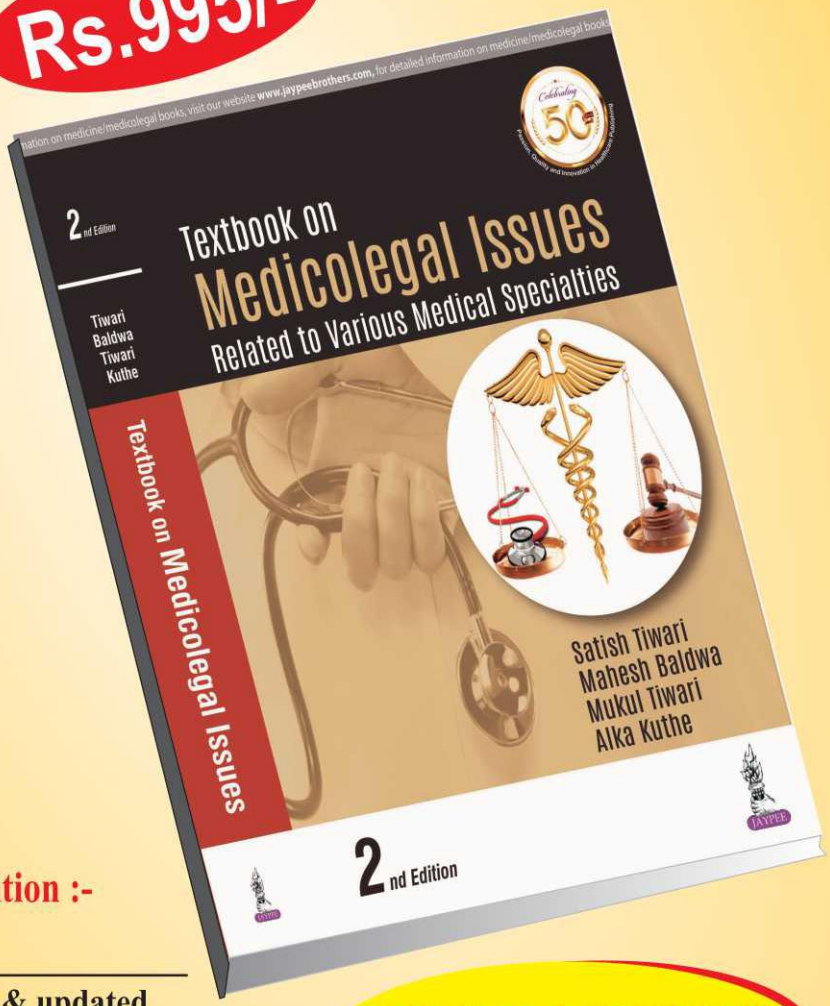

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1)	Dr. Satish Tiwari	(Amravati)	0721-2952851 / 09422857204
2)	Dr. Mukul Tiwari	(Gwalior)	9827383008
3)	Dr. Rajendra Borkar	(Wardha)	9822240837
4)	Dr. Ashish Jain	(Gurugram)	9350506899
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