Bridges CB, Uyeki TM. Emergence of a novel swine-origin influenza A (H1N1) virus in humans. *N Engl J Med*. 2009 Jun 18;360(25):2605-15.
3. Chan M. Transcript of statement by Margaret Chan, Director General of the World Health Organization [Internet] Geneva: WHO; 2009 Jun 11 [cited 2009 Sep 19]. Available from: http://www.who.int/mediacentre/influenzaAH1N1_presstranscript_20090611.pdf.
4. Kinlaw K, Barrett DH, Levine RJ. Ethical guidelines in pandemic influenza: recommendations of the Ethics Subcommittee of the Advisory Committee of the Director, Centers for Disease Control and Prevention. *Disaster Med Public Health Prep*. 2009 Dec;3(Suppl 2):S185-S192.
5. World Health Organization. Ethical considerations in developing a public health response to pandemic influenza [Internet]. Geneva: WHO; 2007 [cited 2009 Nov 4]. Available from: http://www.who.int/csr/resources/publications/WHO_CDS_EPR_GIP_2007_2c.pdf.
6. Gostin LO. Pandemic influenza: public health preparedness for the next global health emergency. *J Law Med Ethics*. 2004 Winter;32(4):565-73.
7. Kass NE. An ethics framework for public health and avian influenza pandemic preparedness. *Yale J Biol Med*. 2005 Oct;78(5):239-54.
8. Kotalik J. Preparing for an influenza pandemic: ethical issues. *Bioethics*. 2005 Aug;19 (4):422-31.
9. Gostin L. Public health strategies for pandemic influenza: ethics and the law. *JAMA*. 2006 Apr 12;295(14):1700-4.
10. Gostin LO. Medical countermeasures for pandemic influenza: ethics and the law. *JAMA*. 2006 Feb 1;295(5):554-6.
11. World Health Organization. Ethical considerations in developing a public health response to pandemic influenza. Geneva: WHO; 2007 [cited 2009 Nov 4]. Available from: http://www.who.int/csr/resources/publications/WHO_CDS_EPR_GIP_2007_2c.pdf
12. University of Toronto, Joint Centre for Bioethics, Pandemic Influenza Working Group. Stand on guard for thee: ethical considerations in preparedness planning for pandemic influenza [Internet]. Toronto: JCB; 2005 Nov [cited 2009 Nov 4]. Available from: http://www.jointcentreforbioethics.ca/publications/documents/stand_on_guard.pdf.
13. Vawter DE, Gervais KG, Garrett JE, Pandemic Influenza Ethics Work Group. Allocating pandemic influenza vaccines in Minnesota:recommendations of the Pandemic Influenza Ethics Work Group. *Vaccine*. 2007 Aug 29;25(35):6522-36.
14. New Mexico Department of Health. Pandemic Influenza Emergency Response, Ethics Guidance and Matrix. [Internet]. 2006 Nov [cited 2009 Nov 5]. Available from: http://www.health.state.nm.us/ohem/documents/appendix%2012%20ethics%20Web%20Ready.pdf.
15. Thompson AK, Faith K, Gibson JL, Upshur RE. Pandemic influenza preparedness: an ethical framework to guide decision-making. *BMC Med Ethics*. 2006 Dec 4;7:E12.
16. Bernstein M, Hawryluck L. Challenging beliefs and ethical concepts: the collateral damage of SARS. *Crit Care*. 2003 Aug;7(4):269-71.
17. Singer P, Benatar SR, Bernstein M, Daar AS, Dickens BM, MacRae SK, Upshur RE, Wright L, Shaul RZ. Ethics and SARS: lessons from Toronto. *BMJ*. 2003 Dec 6;327(7427):1342-4.
18. Oshitani H, Kamigaki T, Suzuki A. Major issues and challenges of influenza pandemic preparedness in developing countries. *Emerg Infect Dis*. 2008 Jun;14(6):875-80.
19. Uscher-Pines L, Omer SB, Barnett DJ, Burke TA, Balicer RD. Priority setting for pandemic influenza: an analysis of national preparedness plans. *PLoS Med.* 2006 Oct;3(10):e436.
20. Chakraborti C. Lessons from the response to A H1N1 influenza, 2009, India: ethics in pandemic planning. *Indian J Med Ethics*. 2010;7(4):216-9.
21. http://english.peopledaily.com.cn/ 200305/23/eng20030523_117091.shtml (accessed 1 Nov 2009)
22. Gardiner D. Are you coming to work during pandemic flu? *Anaesthesia*. 2008 Aug;63(8):803-5.
23. Barr HL, Macfarlane JT, Macgregor O, Foxwell R, Buswell V, Lim WS. Ethical planning for an influenza pandemic. *Clin Med*. 2008 Feb;8(1):49-52.
24. Pahlman I, Tohmo H, Gylling H. Pandemic influenza: human rights, ethics and duty to treat. *Acta Anaesthesiol Scand.* 2010 Jan;54(1):9-15.
25. Sokol D. Ethics and epidemics. *Am J Bioet.* 2008 Aug;8(8):28-9.
26. Alexander C,Wynia M. Ready and willing? Physicians' sense of preparedness for bioterrorism. *Health Aff (Millwood)*. 2003 Sep-Oct;22(5):189-97.
27. Damery S, Draper H, Wilson S, Greenfield S, Ives J, Parry J, Petts J, Sorell T. Healthcare workers' perceptions of the duty to work during an influenza pandemic. *J Med Ethics*. 2010 Jan;36(1):12-8.
28. Shiao J, Koh D, Lo LH, Lim MK, Guo YL. Factors predicting nurses' consideration of leaving their job during the SARS outbreak. *Nurs Ethics*. 2007 Jan;14(1):5-17.
29. Kass NE. An ethics framework for public health. *Am J Public Health*. 2001 Nov;91(11):1776-82.
30. World Health Organization. Pandemic influenza preparedness and response: a WHO guidance document [Internet]. Geneva: WHO; 2009 [cited 2010 Jan 1]. Available from: http://www.who.int/csr/disease/influenza/PIPGuidance09.pdf.

Free medical care and consumer protection

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Abstract

This paper will examine the question of whether patients, who receive free medical care, whether from private charitable or governmental hospitals, can claim rights as 'consumers' under the Consumer Protection Act, 1986. The issue will be discussed from a constitutional perspective as well as that of the law of torts.

The courts have recognised the people's right to proper healthcare and have also spelled out standards for such care and standards for determining negligence. In the landmark case of P*aramanand Katara v. Union of India* (1), the Supreme Court of India emphasised the need for rendering immediate medical aid to injured persons to preserve life, and the obligations of the state in this context. In addition to the constitutional mandate, from the viewpoint of tortious liability, the Bolam test lays down that any reasonable man entering an area of work which requires the attainment of a particular level of learning in order to be called a professional of that field impliedly assures those dealing with such a professional that the skill which s/he professes to possess shall be exercised and with a reasonable degree of care and caution (2). In this regard, the Court observed:

> From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag

> behind other ordinary assiduous and intelligent members of his profession in the knowledge of new advanced, discoveries and developments in his field. He should have such awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more.

Going by the fundamental premises established through the above rulings, even government hospitals, providing medical care free of cost, and the medical officers employed therein are duty bound to extend medical assistance for preserving human life, failing which negligence would be imputed to the act of the concerned authority. As stated in the case of *Laxman Balkrishna Joshi (Dr) v. Dr Trimbak Bapu Godbole* (3),

> ...a doctor when consulted by a patient owes him certain duties, namely, (a) a duty of care in deciding whether to undertake the case; (b) a duty of care in deciding what treatment to give; and (c) a duty of care in the administration of that treatment. A breach of any of these duties gives a cause of action for negligence to the patient.

This article will examine the question of whether patients in government and charitable hospitals, who have not paid for their treatment, can claim rights as 'consumers' under the meaning of the Consumer Protection Act, 1986(CPA) (4).

The medical profession and the CPA

As pointed out by the Supreme Court in the case of *Poonam Verma v. Ashwin Patel* (5), negligence, as a tort, involves three elements: a legal duty to exercise due care; breach of this duty; and consequent damages.

In *Dr A S Chandra v. Union of India* (6), it was held that service rendered for consideration by private medical practitioners, private hospitals and nursing homes must be construed as "services" for the purpose of Section 2(1) (o) of the Act; persons availing of such services are 'consumers' within the meaning of Section 2(1) (d) of the Act. However, this notion was rejected in *Dr C S Subramanian v. Kumarasamy* (7).

In *Indian Medical Association v. VP Shantha* (8), the question raised was whether the treatment provided by medical practitioners to their patients would constitute "service" under the meaning of the Act and whether patients would be treated as 'consumers' under the same. The apex court noted that the issues arising in the complaints against medical negligence can be speedily disposed of by the procedure being followed by consumer disputes redressal agencies. Section 3 of the Act-- which prescribes that the provisions of the Act shall be in addition to, and not in derogation of, the provisions of any other law for the time being in force -- preserves the right of the consumer to approach the civil court for necessary relief.

The mandate of *Lucknow Development Authority v. M K Gupta* (9) was:

> ...the entire purpose of widening the definition is to include in it not only day to day buying and selling activity undertaken by a common man but even such activities which are otherwise not commercial in nature yet they partake of a character in which some benefit is conferred on the consumer,...

According to this judgment, the definition of "service" as contained in Section 2(1) (o) of the Act was construed to be very wide. The distinction between a "contract of service" and a "contract for services" was also stressed (10). A "contract for services" implies a contract whereby the party rendering service is not subject to detailed direction and control but exercises professional or technical skill, knowledge and discretion (11). A "contract of service" involves an obligation to obey orders in the work to be performed and as to its mode and manner of performance (12).

Since there is no relationship of master and servant between the doctor and the patient, the contract between the medical practitioner and his patient cannot be treated as a contract *of* personal service. It is a contract *for* services, and service under such a contract is not covered by the exclusionary part of the definition.

Free medical care not covered by the CPA

The Court, however, chose to adopt a restricted approach for cases pertaining to *free* medical care. It distinguished between circumstances in which services are rendered free of charge to everybody availing of them; when services must be paid for by everybody availing of them; and when they must be paid for but which are available free to persons who cannot afford to pay. It ruled that services rendered by doctors and hospitals falling in the third category would fall within the ambit of a "service" as defined in Section 2(1) (o) of the Act. Thus persons who are rendered free service are "beneficiaries" and as such come within the definition of "consumer" under Section 2(1) (d) of the Act.

However, the Court also held that the salary paid by government hospital administrations to employee medical officers in such institutions cannot be regarded as payment made on behalf of the person availing of the service. Nor can it be considered that such payments coming from taxes are made for the benefit of the person using the service.

The right to health and healthcare

The Universal Declaration of Human Rights states that everyone has the right to a standard of living adequate for the health and well being of himself and of his family (13: Article 25(2)). Article 39(e) of the Indian Constitution enjoins the state to direct its policies to secure the health and strength of workers (14). The term 'health' implies more than an absence of sickness. The maintenance of health is an imperative constitutional goal whose realisation requires interaction by many social and economic factors (13: Articles 22-25).

Primary health centres (PHCs) are the foundation of the rural healthcare system in India. Services provided by PHCs are targeted at the poor who are otherwise unable to afford healthcare. A large number of people receive free healthcare services, and these services can also entail risks and vulnerability to negligence. These numbers also imply a high level of duty of care and responsibility on the part of the doctor as well as the administration. The same is true of services provided by charitable organisations, and there are thousands of such centres all over the country, including in remote areas, providing surgical and medical treatment of various levels of sophistication to millions of patients. The situation, therefore, cannot be artificially distinguished from a case where the consumer is paying for the medical service. Given these figures, it is obvious that the artificial distinction between free and paid medical service needs to be reconsidered while ascertaining the liability of service providers from the perspective of both the Constitution and the law of torts. In fact, excluding patients in government and charitable hospitals from the CPA penalises the poorest of the poor: they are forced, out of poverty, to seek free care and for this very reason denied the right to demand a certain standard of care, and be compensated if that standard is not maintained. If such a stand of law is accepted, it would result in the deprivation of essential human rights for an individual based merely on his economic incapacity. This cannot, by any stretch of the imagination, be the force and purpose which the law seeks to achieve.

Healthcare and consumer rights for the poor

This right has evolved in the United States. Since the patient rights movement of the 1970s, patients have received more protection than consumers in other circumstances. For example, while the latter may have access to some of their credit information, patients are entitled to all the information in their medical records because the information belongs to them (15). Further, a series of court decisions have recognised patients' rights to emergency care (16) and culminated in state and federal legislation requiring hospitals with emergency departments to provide care to patients with emergency medical conditions regardless of insurance coverage or the ability to pay (17). This is the only right to medical care enjoyed by all Americans (18). The right to emergency care is an entitlement unique in common law and it is justified entirely by patient need. Not even housing or education assumes equal importance in the law (19).

Recent developments starting from the 1980s in the US have also seen a transition in favour of managed care organisations from a fee-based service where even the recipients of free medical care get their rights converted into those of private enforcement (20). The earlier fiduciary relationship has now metamorphosed into a contractual obligation wherein the poorer sections can assert themselves as consumers even more (21). The corporatisation of the previous scheme has actually resulted in providing a more systematised expression to the grievances of these people whose problems can now be settled through an internal redressal mechanism through appointment of ombudsmen (22).

Clearly our system would do well to take a leaf out of the US book with regard to a greater recognition and enforceability of rights of such patients in an attempt to usher in a new era of consumer protection.

References

1. AIR 1989 SC 2039.
2. *Eckersley v. Binnie* (1990) 18 Con LR 1.
3. AIR 1969 SC 128.
4. The Consumer Protection Act, 1986. (Act 68 of 1986). Government of India. Available from: http://ncdrc.nic.in/1_1.html
5. (1996) 4 SCC 332.
6. (1992) 1 Andh LT 713.
7. (1994) 1 MLJ 438.
8. AIR 1996 SC 550.
9. AIR 1994 SC 787.
10. Halsbury HSG. Halsbury's Law of England. 4th ed. London: Butterworths; 1984;16:para 501.
11. Cane P, Conaghan J. *The New Oxford Companion to Law*. 1st ed. London, Oxford University Press; 2008:1134.
12. *Simmons v. Heath Laundry Co.* (1910) 1 KB 543.
13. United Nations. *Universal Declaration of Human Rights*. UN General Assembly. 1948 Dec 10.
14. *Bandhua Mukti Morcha v. Union of India* AIR 1984 SC 802.
15. Yarmolinsky A. Supporting the patient. *New Engl J Med.* 1995 Mar 2;332(9):602-3.
16. *Manlove v. Wilmington Gen. Hosp.*, 174 A.2d 135 (1961).
17. McKitrick AJ. The effect of state medical malpractice caps on damages awarded under the Emergency Medical Treatment and Active Labour Act. *Cleveland State Law Review*. 1994;42:171-201.
18. *Estelle v. Gamble*, 429 US 97 (1976).
19. *City of Cleburne v. Cleburne Living Ctr, Inc,* 473 US 432 (1985).
20. Trubeck LG. The social HMO for low-income families: consumer protection and community participation. *Seton Hall Law Review.* 1996;26:1143-1151.
21. Morriem EH. More justice and legal justice in managed care: the ascent of contributive justice. *Journal of Law and Medical Ethics*. 1995; 23(3):247-265.
22. Hyman DA. Drive through deliveries: is "consumer protection" just what the doctor ordered? *North Carolina Law Review*. 78:5-99.