Consumer protection - Law and legislation - Pakistan.

Approval Sheet

This is to certify that we have evaluated the thesis entitled "Malpractices of Medical Professionals Under Consumer Protection Law in Pakistan: A Critical Study" submitted by Ms. Afsana Bibi, Roll # 342FSL/LLMCL/F11 in partial fulfillment of the award of the degree of LL.M in Corporate Law. The thesis fulfills the requirements in its core and quality for the award of the degree.

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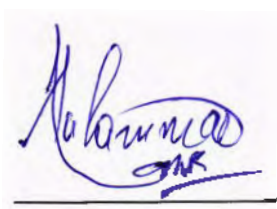

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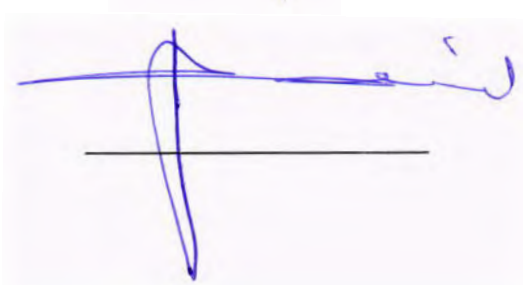

Dedication

I dedicate this work to my grandfather **Muhammad Jan Syed** (late), who offered unconditional Love and had been a constant source of support during the challenges of my life and always were there for me.

MAY HIS SOUL REST IN PEACE!

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I humbly thank Allah Almighty, the most merciful and beneficent, who gave me health thought and co-operative people to enable me to achieve this goal.

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Last but not the least I am thankful to my University for providing me a platform for this work.

Author's declaration

I Afsana Bibi, candidate for the award of the LL.M. degree, declare that the work in this thesis was carried out in accordance with the requirements of the University's Regulations. It has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate's own. Any views expressed in the dissertation are those of the author.

SIGNED: ..... DATE: 1-6-2017

LIST OF ACRONYMS

CPA:	CONSUMER Protection Acts
CPO:	Consumer Protection Ordinance
DCPC:	District Consumer Protection Councils
PCPC:	Provincial Consumer Protection Councils
PCPA:	Punjab Consumer Protection Act
CPC:	Consumer Protection Council
PMDC:	Pakistan Medical & Dental Council
COOP:	Cooperative Consumers Society
CRCP:	Consumer Rights Commission of Pakistan
UNC:	United Nation Charter
UNDHR:	United Nation Declaration of Human Rights
WTO:	World Trade Organization
WHO:	World Health Organization
CDRAs:	Consumer Dispute Redressal Agencies
NCDRC:	National Consumer Dispute Redressal Commission
NCMA:	National commission for Medical Arbitration

FTC:	Federal Trade Commission
TILA:	Truth in Lending Act
FCRA:	Fair Credit Reporting Act
FBCA:	Fair Credit Billing Act
FDCPA:	Fair Debt Collection Practices Act
FCCCA:	Fair Credit and Charge Card Disclosure Act
CCRA:	Consumer Credit Reporting Reform Act
FACTA:	Fair and Accurate Credit Transactions Act
CROA:	Credit Repair Organizations Act
CARD:	Credit Card Act

Abstract

This thesis basically focused on the Malpractices of Medical professionals and the rights of patients/consumers under the various consumer Laws and existing Legal mechanisms available in Pakistan. Consumers/patients are not only unaware about the patient's doctor relationship but also unresponsive about the laws and Legal remedies available for their protection. This research paper is an effort to take a broader view of patients' issues with magnifier of current consumer Laws.

In the first chapter of thesis, the development of medical negligence law was traced briefly. After identifying the meaning of medical negligence and malpractice, the meaning of "medical professional" was examined, because it is the negligence of the professional that is termed "malpractice." The constitutional and international standards were noted and then the remedies available to patients or those who have suffered injuries were examined in general. The remedies available in Pakistan were also referred to in general terms and it was then stated that Pakistan is moving towards the Indian model of granting relief to patients in cases of medical negligence through the consumer law, with the lead being taken by Punjab.

In second chapter, we examined in detail the broad features of this law, and how it operates within the province of Punjab. This included the study of the various authorities proposed to be set up under this law. The major issues that are likely to create obstacles need to be pointed out too, without

being overly critical. The types and nature of damages awarded for medical malpractice cases were analyzed . the state of recent legislation on consumer laws along with some earlier statutes that pertain to consumers were breifly examined.

In the third chapter, a study was conducted to assess the other models that were adopted in the developing world. After assessing the factors that beset the developing countries—like poverty, excess of infectious diseases, lack of medical infrastructure, paucity of trained professionals and the like—two major models dealing with medical malpractice were taken up and described.

In the end, it was concluded that the model adopted by Mexico was more suitable for developing countries as compared to the consumer law based model adopted by India. In addition, it was concluded that one of the major reasons for the failure of the consumer law based system was the lack of medical experts available for the purpose of testifying for the plaintiff as one doctor would not go against another fellow doctor. Another reason was the non-availability of medical records to the patient who had filed a claim against a doctor or a hospital. The situation would be much better if these areas were subjected to reform and improvement.

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THE DEVELOPMENT OF MEDICAL NEGLIGENCE LAW IN PAKISTAN

1.1 Introduction

A medical negligence case[1] in which the Supreme Court of India imposed damages that are likely to touch more than 11 crores (equivalent to 20 crores in Pakistan) made headlines in many newspapers and online publications, one of which is quoted below:

> Nobody wants India to go the way of the United States where lawsuits have helped push up the cost of medical insurance to make healthcare itself unaffordable for millions. But the record damages imposed on the AMRI hospital in Kolkata by the Supreme Court in a 210-pages judgement on Thursday at least gives some hope that we are not at the mercy of a medical establishment that both plays God and Shylock, trying to extract every pound of flesh from its patients but remaining completely unaccountable at the same time. The Court ordered compensation of Rs 5.96 crore for the death of Anuradha Saha for medical negligence. The amount itself made huge news because it crosses 11 crore once simple interest is taken into account. It's no slap on the wrist.The Court made it clear that it was sending out a message that was not about Anuradha Saha alone. "We therefore hope and trust that this decision acts as a deterrent and a reminder," it said.[2]

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1. Dr. Balram Prasad v. Dr. Kunal Saha & Others, SC (India) Civil Appeals No. 2867, 692, and .2866 of 2012.

2. Sandip Roy, "Anuradha Saha case: Does SC judgment bring hope?" available at http://www.firstpost.com/living/anuradha-saha-medical-negligence-case-does-sc-judgment-bring-hope-1193737.html (accessed May, 2015).

CHAPTER1: THE DEVELOPMENT OF MEDICAL NEGLIGENC LAW IN PAKISTAN

The message, if heard by no one else, must have been heard by the Supreme Court of Pakistan, which is probably waiting anxiously for a ripe medical negligence case to arrive at its door. Pakistan is also in the process of adopting the Indian model of including medical services under the term "services" in the newly adopted consumer Acts, with the Province of Punjab taking the lead[3] and others likely to follow suit, including the Federal Capital.[4] The Punjab law has also created institutions and other mechanisms on the pattern of the Indian model,[5] but there is a total lack of awareness of this law, its standards, and procedures among the public as well as the medical professionals who can be made liable for acts of negligence. The system conceived under this law needs to be understood thoroughly, and problems lidentified, not only for the sake of the other Provinces that may alter their consumer laws to include medical negligence, but also the people involved, both medical professionals and patients. This study attempts to fill this need.

1.2 The New Image of Medical Professionals

Medicine, which has a direct relationship with and power over man's health and his pains, has always been considered a sacred activity with an almost godlike status and respect. It was due to this lofty position in society that it has often protected by a genuine immunity.[6] This respect was also available to the physician within the Islamic civilization, because of which many jurists, like Ibn Rushd, were also physicians, and were granted so much respect. "The word **doctor** is derived from the Latin word

3. The Punjab Consumer Protection Act 2005 (Pb. Act II of 2005)

4. The Consumer Protection Acts of the other Provinces have not altered the definition of "services" as yet to include medical services.

5. See, e.g., Part VII of the Punjab Act, Consumer Protection Council.

6. Maurizio Rippa Bonati, and Fabio Zampieri, "Historical Overview of Medical Liability", in *Malpractice and Medical Liability: European State of the Art and Guidelines*, ed., Santo Davide Ferrara, (Heidelberg: Springer, 2013), 13.

docere,which means to teach." So "The doctor is a person who guides and teaches his patients about how to maintain health and prevent diseases."[7] This respect had actually come down from the earliest time, especially that of the Greeks.[8] Gabriele Zerbi, a well known doctor of medicine and philosophy, and the author of, "***De cautelis medicorum***" that is one of the very first manuals of medical ethics, says in this manual: "In the remotest times of Greek Medicine, the person of the physician, more than a common human being, is an infallible priest who interprets the will of a determined deity, and is far from being susceptible to the errors of a common mortal."[9] Early physicians like Zerbi advocated that the physician should avoid "harm" and "injustice." To avoid injury and unfairness, the doctor must establish his exercise on his personal "judgment" and base it on caution.[10] Things began to change with an increase in scientific knowledge:

> [A]round the middle of the nineteenth century, the above picture began to change rapidly in modern industrialising states such as England and Germany. Breakthroughs in the understanding of diseases, the development of antiseptics and anaesthetics, and the discovery of the X-ray as a diagnostic tool all dramatically increased the doctor's scope for successfully recognising and treating illness in his patient. During the twentieth century further developments continued apace: a major new

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7. *The New International Webster's Comprehensive Dictionary of the English Language*, s.v."doctor".

8. Bonati and Zampieri,"Historical Overview of Medical Liability," 14.

9. G. Zerbi, *De cautelismedicorum* (Christophorus de Pensis, Pata vii, 1495), as quoted in Bonati and Zampieri, "Historical Overview of Medical Liability,"", in Malpractice and Medical Liability: European State of the Art and Guidelines,ed., Santo Davide Ferrara, (Heidelberg: Springer, 2013),16.

10. Ibid. "In spite of the 'caution' that Zerbi professed, the Veronese doctor was a victim of the wrath of the relatives of his famous patient, the Turkish Sultan: they eventually ordered his brutal execution." Ibid., 17.

> advance was the discovery of antibiotics; more recently, the treatment and palliation of chronic long-term conditions has benefited from the development of modern pharmaceutical products.[11]

The author goes on to explain that improvement in medical care coincided with the emergence of modern states, which began focusing on social regulation and welfare provisions. Earlier, access to medical services had been a disorganized affair, and only those who could pay received treatment, unless the charities helped. With the improvement in the efficacy of medicine, especially in tackling contagious disease, the state began participating in the provision of health care facilities to the population at large.[12]

Today, the medical profession has a new face, and a new reputation. Health care has now become a business run by huge hospitals, and it is this business that determines the patient-doctor relationship.[13] As the profession changes into a business, and the professionals into businessmen, the quality of service deteriorates and the people appear to be at the mercy of the medical businessman. Thus, the news reports are full of articles like *Medical negligence: A growing problem in Pakistan*; *Postcard USA: Pakistan's doctors who kill*; *PMDC lacks authority to deal with medical negligence cases.*[14] The medical profession is, therefore, rapidly becoming

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11. Marc Stauch,*The Law of Medical Negligence in England and Germany: A Comparative Analysis"* (Portland, Oregon: Hart Publishing, 2008), 3.

12. Ibid.

13. "Centers for Medicare and Medicaid Services", available at http://www.cms.hhs.gov/NationalHealthExpendData (accessed January 23, 2015). See also Peter F Drucker, "What business can learn from nonprofits," *Horvard business review*67, no. 4 (1989): 88–93; and Joel C Cantor et al., "Business leaders' views on American health care," *Health Affairs*10, no. 1 (1991): 98–105.

14. For all these references, see Muhammad Hanif Shiwani and Amin A. Muhammad Gadit, *"Medical negligence: A growing problem in Pokistan"*, *Journal of Pakistan Medical*

commercialised and dehumanized. Stories abound about the deceptive methods adopted by doctors and hospitals to fleece their patients. Among these are the undergoing of needless tests, in selected laborotaries, the prescribing of particular medicines in league with the salesmen of paharmaceutical companies and numerous other tricks that we need not mention here as they are well known. On the one hand, there is a noble profession that has been reduced to the level of a lowly business, and on the other there is a duped public that is neither aware of its rights nor is it prepared to face the lengthy and painful court procedures to seek compensation.

The lobby of medical professionals, in the form of the PMDC, appears to be so powerful that until recently there were only two judgements by the superior judiciary in more than six decades. A document published by the Consumer Network has the following to say:

According to Advocate Nasir Maqsood from Karachi:

> We have only two judgments on medical negligence in Pakistan from 1947 to 2003.There are many reasons for the absence of medical malpractice litigation culture in Pakistan. Mainly, pertain to general lack of awareness on the part of patients about their healthcare rights, social norms and belief systems whereas some pertain to administrative and legal domain.[15]

More recently, however, probably due to a steep rise in cases of medical negligence, more cases are coming to the courts, but the remedies available to the

Association,available at http://jpma.org.pk/full_article_text.php?article_id=2837(accessed May 8, 2015).

15. The Network for Consumer Protection,*Medical Negligence: Tragedy Under Wraps* (Islamabad: The Network Publications, 2006), 16.

victims are inadequate and insignificant.[16] The main cause of people not having recourse to the courts is the lack of awareness amongst the general public about their healthcare rights. This absence of awareness is to be found not only in the illiterate majority, but also among the educated people.[17] Whether educated or illiterate, the people also do not want to be locked up in an endless strife in the courts, especially after having suffered at the hands of the noble medical profession.[18]

1.3 The Meaning of Medical Negligence and Medical Malpractice

1.3.1 Malpractice Pertains to Professionals

Medical malpractice law revolves around the concept of negligence.[19]"When an act performed on an individual results in injury in a situation in which there is no intent to injure, it is called negligence." "Negligence is defined as not doing something that a reasonable person would do or doing something that a reasonable person would not do."[20] When a professional commits negligence it is called malpractice. This may apply to any professional: lawyer, engineer, chartered accountant and so on. Thus, medical malpractice is a professional's negligence.[21]The plaintiffs often sought recourse for breach of contract when civil actions for malpractice were contemplated

16. Salman Siddiqui, "Low compensation for medical negligence", available at http://www.thenews.com.pk/Todays-News-3-204735-Low-compensation-for-medical-negligence. (accessed May 12, 2015).

17. Consumer Protection, *Medical Negligence,* 12.

18. Many disputes never go to court: "It is estimated by malpractice attorneys that fewer than 10 percent of the malpractice lawsuits that are filed actually go to court. It is also estimated that of those that go to court, only 10 percent follow through to a final judgment. The remaining cases are settled out of court either by plea bargaining, agreement, arbitration, or mediation. Settling out of court may take place any time prior to judgment." Myrtle Flight, *Law, Liability and Ethics: for Medical Office Professionals,* 5th ed. (United States of America: Delmar, Cengage Learning, 2011), 20-21.

19. Michelle M. Mello, and David M. Studdert, *"The Medical Malpractice System: Structure and Performance,"* in *Medical Malpractice and the U.S. Health Care System*, ed.William M. Sage and Rogan Kersh (Cambridge University: Cambridge University Press, 2006), 11.

20. Flight, *Law, Liability, and Ethics*, 94.

21. Ibid.

in the nineteenth century, whereas in the 20th century all malpractice action have been tortious actions based on the legal concept of negligence.[22] The law was laid down in *Rex v. Bateman* as follows by Lord Hewart CJ:

> The law as laid down in these cases may be thus summarised: If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his discretion and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward. It is for the judge to direct the jury what standard to apply and for the jury to say whether that standard has been reached. The jury should not exact the highest, or a very high, standard, nor should they be content with a very low standard. The law requires a fair and reasonable standard of care and competence be reached in all the matters above mentioned.[23]

The law in Germany still favours the action under contract law. In fact, this is a key distinction between the English and German approaches to medical malpractice claims, although in the outcome there may not be too much difference in the two

22. Neal C. Hogan,*Unhealed Wounds: Medical Malpractice in the Twentieth* Century (New York: LFB Scholarly Publishing LLC, 2003), xii.

23. Rex v. Bateman, (1925) 19 Cr App R 8.

systems.[24] Thus, in a contract dispute the patient argues that the doctor contracted to cure a specific ailment, and that given the absence of a cure, the patient is entitled to compensation, while under tort law a physician is held responsible for his negligence in performing a procedure if that negligence results in harm to the patient.[25]

To explain this further, the training , experience and skills of the professional needed to be taken into consideration while deciding whether an act resulting in injury should be taken as mere "negligence" or "malpractice". To repeat, "malpractice is a term associated with any professional misconduct and implies a greater duty of care to the injured person than the reasonable person standard."[26] The term implies that a doctor, nurse, or other licensed medical practioners have special knowledge, which raises the expectations of society.[27] If a regular surgeon is not available, for example, and a physicia performs an appendectomy, he may not be subjected to the same high standard to which a surgeon is held, that is, a trained surgeon will be considered to a higher standard of care than a general practitioner performing the same operation.[28] The reason is that the surgeon has special knowledge, training, and experience, which shows the society that s/he is better qualified to perform an appendectomy.[29] To be labeled as a professional, an expert must belong to a certifying or licensing organization with professional standards against which a defendant's adequacy may be compared.[30]

We have mentioned "negligence" above as an action contemplated under the law of torts, and have also mentioned contract. These, however, are not the only remedies

24. Stauch, *Medical Negligence*, 9.
25. Hogan, *Unhealed Wounds*, xii.
26. Flight, *Law, Liability, and Ethics*, 94.
27. Ibid.
28. Ibid.
29. Ibid.
30. Ibid.

available to the patient under the law. It may be possible, under certain circumstances, for the patient to seek criminal prosecution, and more recently there is the consumer law that has been brought into service. We may turn to the various remedies available to the patient under the law, and while doing so we may examine where Pakistan stands with respect to each of these remedies. Before doing this, however, it will be better to understand the significance attached to health care by the constitutional and international standards.

1.3.2 Constitutional and International Standards

ARTICLE 9 and 38 of Constitution of Pakistan:

The Courts in Pakistan (and India) have interpreted Article 9 that deals with security of the person and the right to life and liberty as guaranteeing the right to a doctor's assistance and the right to health and a healthy and safe environment. A number of judgements discuss this significant right: AIR 1989SC 2039; 2010 PLC (CS) 1961; AIR 1995 SC 922. Article 38 (d), which is a principle of policy, acknowledges the provision of medical relief as a principle of policy.

United Nation Charter:

The right to medical care is acknowledged by the United Nation Charter, which provides the basis on which the other instruments are built. Article 55 says:

> With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

a. higher standards of living, full employment, and conditions of economic and social progress and development;
b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and
c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.[31]

Universal Declaration of Human Rights:

Art 25(1) of 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, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment sickness, disability, widowhood, old age or other lack of livelihood in circumstance beyond his control.[32]

International Covenant on Economic Social and Cultural Rights:

Article 12 of International Covenant on Economic Social and Cultural Rights states:

31. United Nations Charter available at http://www.un.org/en/sections/un-charter/un-charter-full-text/index.html (accessed July 27, 2016).
32. Universal Declaration of Human Rights available at http://www.un.org/en/universal-declaration-human-rights/ (accessed July 27, 2016).

(1) The states parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

(2) The step to be taken by the states parties to the present parties to present covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the still birth- rate and of infant morality and for the healthy development of the child:

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of condition, which would assure to all medical service and medical attention in the event of sickness.[33]

Convention on Elimination of All Forms of Discrimination against Women 1979:

Art 14(2)(b) of the Convention on Elimination of All Forms of Discrimination against Women 1979 states: "To have access to adequate health care facilities, including information, counseling and service in family planning."[34]

United Nations Conventions on the Right of the Child 1989

33. International Covenant on Economic Social and Cultural Rights: available at http://pwescr.org/PWESCR_Handbook_on_ESCR.pdf. (accessed July 27, 2016).

34.Convention on Elimination of All Forms of Discrimination Against Women, 1979. Available at http://www.ipu.org/PDF/publications/cedaw_en.pdf. (accessed July 27, 2016).

Art. 24(1) United Nations Conventions on the Right of the Child, 1989 goes to great lengths to talk about the health and health care to be provided to the child. Thus, it begins withe the following words: "States parties to recognize the right of the child to the employment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States parties shall strive to ensure that no child is deprived of his or her right of access to such health care service."[35]

Resolution of the United Nations:

A very important instrument is a resolution of the United Nations, G.A. Res. 39/248, U.N. Doc. AIRES/39/248 (Apr. 16, 1985). This resolution asked signatories, particularly developing countries like India, to improve consumer protection laws, including "measures enabling consumers to obtain redress."[36]

1.4 The Different Remedies for Medical Negligence

1.4.1 Medical Negligence and the Criminal Law

An excellent article that traces criminal prosecution of doctors, and other professionals, from the year 1795, concludes by saying that the criminal prosecution of a doctor is appropriate when there is "clear evidence of violation of safety rules."[37] The paper reasons that human error is unavoidable in the course of care, therefore,

35. United Nations Conventions on the Right of the Child, 1989.
36. See The Consumer Protection Act, 1986, No. 68, Acts of Parliament, 1986.
37. Robin E Ferner and Sarah E McDowell, "Doctors charged with manslaughter in the course of medical practice, 1795-2005: a literature review, "*Journal of the Royal Society of Medicine*99, no. 6 (2006): 6.

"charging doctors with manslaughter following a medical error may be an emotionally satisfying way to exact retribution, but if individual doctors are singled out for punishment it will become much harder to foster an open culture."[38]

Prosecutions for medical killing are based on the concept of gross negligence.[39] In a 19th century case the court had noted that "if there was only the kind of forgetfulness which is common to everybody, or if there was a slight want of skill…it would be wrong to proceed against a man criminally in respect of such injury."[40] The court then described as an example of gross negligence,"the surgeon who operated while drunk".[41] There are some who advocate that where there is an accident someone has to be blamed. Nevertheless, in most jurisdictions, prosecution of doctors under the criminal law has been rare. But a criminal complaint may be instituted against medical professionalsaccusing commission of rash and negligent acts causing death.[42] Thus, it has been reiterated in *Suresh Gupta v. Govt. of NCT of Delhi*[43] that "the burden of proof is on the patient is to prove that the physician was grossly negligent."

An author tracing criminal medical liability in Spain, provides a highly useful list of areas in which criminal liability of doctors or medical professionals can aris, although they are rarely prosecuted.[44] There are different reasons behind it; Forexample, the burden of proofs rests with patients and mostly, it is very difficult to prove the specific event from which the damage resulted.[45] The list drawn from the

38. Ibid., 6.
39. R v Bateman (1925) 19 Cr App R 8, 11.
40. R v Doherty (1887) 16 Cox CC 306, 309.
41. Ibid.
42. The Indian Penal Code, Act 45 of 1860, Section 304A.
43. 2004 (6) SCC 422.
44. Mara Castellano Arroyo and Ricardo de ngel Ygez, "Medical Responsibility and Liability in Spain," in Malpractice and Medical Liability: European State of the Art and Guidelines, ed. Santo Davide Ferrara (Heidelberg: Springer, 2013), 169.
45. Ibid., 169.

Spanish Criminal Code classifies a series of actions that may be performed intentionally, or recklessly:

> Homicide due to professional recklessness; inducement to suicide; euthanasia; abortion due to professional recklessness; injuries due to professional recklessness; a serious or nonserious deformity; or a serious or nonserious somatic or mental illness or mental reduction; harm to the foetus due to professional recklessness; genetic manipulation; omission of the duty to save; supposition of birth or alteration of paternity; against public health; revelation of secrets, professional secret; falsifying certificates; and falsehood in expert evidence.[46]

This list may not be entirely applicable to Pakistan, but it is highly useful.As compared to the above, a comparative study of medical negligence laws in the UK and Germany states that in recent times the criminal law, with its deterrent and punitive functions, has become gradually more important in the regulation of the medical profession.[47] This happens when the doctor fails to gain the patient's consent, reflecting the fact that, both in England and Germany, the non-consensual treatment of a competent adult, even one that apparently benefits him, is unlawful.[48] In England, for example, the doctor may in such a case be liable for criminal assault contrary to the Offences Against The Person Act 1861. As compared to this, in Germany, he is likely to be charged with unlawful bodily injury under Section 223 of the Criminal

46. Ibid., 170.
47. Stauch, *Medical Negligence*, 5.
48. Ibid.

Code.[49] Criminal sanctions also "apply to procedures that are ethically controversial and/or therapeutically dubious and remain unlawful (notwithstanding the patient's consent)—either absolutely or failing the fulfillment of further special conditions."[50] Examples of these procedures given by the author include such matters as embryo research, abortion and euthanasia. Also included are risky irreversible procedures like live organ donation.[51]

The main thing to note about the criminal law is that it may be considered a very troublesom law for the physician due to the seriousness of criminal law, and it may result in professional sanctions from the doctor's point of view—including the loss of his livelihood or even liberty—the rules of the criminal law do not (and are not designed to) offer a remedy to the injured patient. "Instead, to obtain compensation for harm allegedly suffered at the hands of a delinquent doctor the patient must turn to the private law."[52] As compared to this, the criminal law of Pakistan may have some remedy for the patient in the form of *diyat* as a result of injuries caused.

In Pakistan, most of the offences that can be related to malpractice claims are ruled out because of the "consent element." The Pakistan Penal Code, 1860 states in Section 88:

> **Act not intended to cause death, done by consent in good faith for person's benefit**—Nothing, which is not intented to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a

49. Ibid.
50. Ibid.
51. Ibid.
52. Ibid. 6.

consent, whether express or implied to suffer that harm, or to take the risk of that harm.

Illustration: "A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under the painful complaint, but not intending to cause Z's death, and intending, in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence."[53] Section 92 provides,"for exemption for acts done in good faith for the benefit of a person without his consent though the acts cause harm to a person and that person has not consented to suffer such harm". Illustration (c) explains the section by saying: "A, a surgeon, sees a child suffer an accident which is likely to prove fatal unless an operation be immediately performed. There is not time to apply to the child's guardian. A performs the operation in spite of the entreaties of the child, intending, in good faith, the child's benefit. A has committed no offence." Sec. 93 saves from criminality certain communications made in good faith.

The most obvious candidate from the Pakistan Penal Code in this context is section 318 that deals with *qatl khata'*.[54] To this may be added all other cases of *khata'* or mistake in which injuries are caused. The Sindh High Court dealing with *qatl khata'* under section 318 has said that insofar as death is caused by a rash or negligent act and in the specific case of doctors accused of professional negligence, the offence is proved only if the accused acted with "gross negligence" or with reckless disregard or indifference to the consequences of the act, which caused the death. The Court went

53. Pakistan Penal Code, 1860.

54. "Whoever, without any intention to cause death of, or cause harm to, a person causes death of such a person, either by mistake or act or by mistake of fact, is said to commit *qatl-i-khata*." Section 318, Pakistan Penal Code, 1860.

on to say that the standard of negligence in a civil case differs from criminal negligence in two ways: (1) the standard of proof in all civil cases is simply the balance of probabilities, whereas in criminal prosecution the offence has to be proved beyond reasonable doubt. (2) The degree of negligence in a criminal case must be much higher in order to constitute a criminal offence. Such gross negligence alone is punishable. Anything less than this may attract tort liability, but will not come up to the level required for criminal liability.[55] This reasoning is in line with the earliest cases like *R v Bateman (1925)* and even the Indian case *Suresh Gupta v. Govt. of NCT of Delhi.*

In addition to the above, Section 337 deals with the causing of hurt by mistake (*khata*), while Section 338 deals with *Isqat-i-haml* or causing miscarriage of the embryo or child whose organs have not been formed, and Section 338B deals with causing miscarriage when the organs have been formed. There may be other cases, but this topic needs separate treatment. In the cases of unlawful abortion or miscarriage, it will not be a case of negligene or gross negligence, it will be an outright offence.

1.4.2 Remedies Based on Tort Law and Contract Law

In this section we will briefly take up the remedy preferred in the common law world, which is based on tort law, and compare it with the reliance on the law of contract in some civil law countries. In the common law world, we will look at the United Kingdom and the USA, while for the civil law countries we will look at the preferred remedy in Germany.

We may briefly look at the basis of a medical negligence law suit in the United States before moving to the comparison of UK and Germany. We have already stated

55. PLD 2010 Kar 134.

that "when an act performed on an individual results in injury in a situation in which there is no intent to injure, it is called *negligence*". Negligence is defined as "not doing something that a reasonable person would do or doing something that a reasonable person would not do". In the United States, in a trial for negligence, the jury decides that:"the facts of the case, including whether the person against whom negligence has been alleged behaved unreasonably in the circumstances."[56]*Malpractice* differs from negligence in that malpractice is a professional's negligence.[57] When decidingthe diffence between negligence and malpractice, the training and experience of the individual committing needed to be taken into consideration.[58] "Malpractice is a term associated with any professional misconduct and implies a greater duty of care to the injured person than the reasonable person standard."[59] In such cases, reliance is placed on expert witnesses, and often enough evidence is not available.For example, the expert witness informs the jury whether the way in which the surgeon operated was acceptable to majority or minority of other surgeonspracticing under similar circumstances.[60] The courts—recognizing that, in certain cases, evidence of what occurred is not available to the injured person—developed the doctrine of *res ipsa loquitur*, which is translated as "the thing speaks for itself." This rule requires that:

1. In the normal course of events, the accident would not have occurred if reasonable care had been used.

56. Flight, *Law, Liability, and Ethics*, 94.
57. Ibid.
58. Ibid.
59. Ibid.
60. Ibid. 95.

2. The defendant had exclusive control over the cause of the injury.
3. The plaintiff did not contribute to the occurrence of the accident.

Such rules have over the years led to certain basic elements of a a civil medical malpractice lawsuit. Thus, the patient must show that:

1. There was a relationship between the physician and the patient;
2. This relationship established a duty to be performed by the physician with respect to the patient;
3. The duty had been upheld at a professional standard of care;
4. The physician breached the duty to the patient;
5. The patient had a resulting injury; and
6. The physician's breach was the proximate cause of the patient's injury.[61]

The important point to note here is that for a case to exist noot only must all these elements be present, but they must be sequential.[62] Thus, in each case a relationship is first established. This is done under contract law. The relationship then establishes a duty by the physician to the patient. The duty required by the physician is established by the medical profession and/or the expectations of society. It is termed the "standard of care." Accordingly, when "a contract is made between a physician and a patient for medical care, the physician has a duty to the patient that must meet a

61. Ibid., 96.
62. Ibid.

professional standard of care. Breach of the duty by the physician, by action or inaction, is measured against the standard of care."[63]

The above features of a malpractice suit are based on the position in the USA, but they apply to the United Kingdom as well. The basic idea of comparing the method or model followed in the UK with Germany is that "private law," as distinguished from public or criminal law, encompasses the legal rules that apply between individual actors in civil society. The private law operates in a bilateral way, giving rights to one party against the other party and placing the correlative duty on the other party.[64] The two jurisdictions—Uk and Germany, along with other modern legal systems—distinguish broadly between two main institutions of rules, namely of tort or delict and contract. "Generally, tort law plays a wider, but also more negative role in the social order in protecting the *status quo*: in tort what is typically compensated is a setback to a person's existing interests. By contrast, contract law governs agreements between agents aimed at achieving positive results and has, as its focus of compensation, the claimant's disappointed expectations."[65] Tort law is for maintenance of life, health, property, and wealth, while contract law is for promoting their development.

As far as malpractice claims are concerned, a key distinction between the English and German approaches lies in the different importance accorded to contract and tort. Whereas English law has tended to deal with such claims in tort, in German law a contractual solution has been favoured.[66] This makes little difference in practice; rather the law in both countries has put the emphasis on approximating the protection available to the patient under both legal institutions, as well as ensuring that the latter

63. Ibid.
64. Stauch, *Medical Negligence*, 6.
65. Ibid.
66. Ibid.

has a solid defendant to sue.[67]The English courts have fastened upon the doctor's assumption of responsibility for the patient's welfare, coupled with the representation of specialist knowledge and skill in positioning the doctor's duties to their patient in tort law. Thus, it was stated in *R v Bateman* that:

> "If he [the doctor] accepts the responsibility and undertakes the treatment and the patient submits to his discretion and treatment accordingly, he owes a duty to the patient .... No contractual relation is necessary, nor is it necessary that
> the service be rendered for reward."[68]

The pre-eminence of tort has been reinforced in the United Kingdom since 1948. The reason for this is the creation of the National Health Service. If medical care is provided free of cost this works against the requirements of contract, because it requires "consideration."[69] In Germany, in contrast to the position under English law, consideration is not required as an element in contract law, "it is irrelevant whether the patient has private healthcare insurance or is (one of the large majority) treated via a public insurance fund: .... a contractual relationship will arise in cases where treatment is entirely gratuitous (e.g. it takes place between doctors who are friends or colleagues). All that is required is that the doctor indicates willingness to treat, and the patient to be treated."[70]

We need not explore this comparison further, because the basic purpose is to show the types of remedies preferred in different jurisdictions, and the reasons for such

67. Ibid.
68. R v Bateman (1925) 19 Cr App R 8 (CA) 12–13.
69. Stauch, *Medical Negligence*, 9.
70. Ibid., 11.

preference. It is, however, instructive to look at how both models—torts and contracts—focus on what are called the "patient's protected interests."

The Scope of the Patient's Protected Interests

In the treatment context, the patient has an interest in diverse matters over which the doctor, by his conduct, has varying degrees of influence.[71] In practice, it does not matter whether a system follows the tort model or the contractual model. These interests include maintaining "his bodily integrity (to the extent that he does not waive this), participating in the treatment by informed choice, achieving a restoration of health so far as possible, and avoiding unnecessary injury and/or loss."[72]

It is to be noted, however, that it is not every setback to every *de facto* interest that will qualify for compensation. Rather, the patient must show at the outset of his claim that the doctor was under a legal duty to safeguard the interest in question. In England, and the entire common law world for that matter, the majority of patients, when they bring an action, will rely on tort law; whereas in Germany and some other European countries, the primary source of the doctor's obligations is contractual. Nevertheless, "the interests recognised in each country as meriting legal protection (and the correlative duties upon the doctor/hospital) are for the most part very similar."[73] In both jurisdictions some kind of hierarchy of interests may be discerned, with certain central types of interest accorded greater protection by the law than other interests deemed of more contingent importance.[74]

71. Ibid., 11.
72. Ibid., 12-13.
73. Ibid., 13.
74. Ibid.

CHAPTER1: THE DEVELOPMENT OF MEDICAL NEGLIGENC LAW IN PAKISTAN

Medical Negligence and the State of Tort Law in Pakistan

The law of torts is in a very neglected state in Pakistan. The position in India was no better until recently, but India is trying to revive this law. According to one source, there have been only two judgments on medical negligence during the six decades of Pakistan's life.[75] Given below is a quotation from one author who has gone into the details of why the law of torts has failed in Pakistan:

> In the developed common law countries, the law of torts has made great strides, and many new torts have been identified with swift remedies. There have been stirrings in India too, especially after the Bhopal tragedy, but the progress is extremely slow. In Pakistan, the law of torts left by the British has become shriveled acquiring a shrunken posture leaving the poor and the downtrodden without remedies enjoyed by the rest of the world. The law of torts in Pakistan needs to be resurrected from its grave and given a modern form if the rights of the less privileged citizens are to be protected and secured.
>
> Strange as it may sound, many professionals working in senior positions within the legal system of Pakistan can be heard saying that the law of torts does not exist in Pakistan. Is this true? Is Pakistan not a common law country? Does the common law have nothing to do with Pakistan anymore? Before these questions are answered it may be stated at the outset that incredibly the law of torts has a very limited role to play in Pakistan. As a result of this, the rights of many people are trampled upon with impunity and the legal machinery is unable to secure these rights. The rich may obtain relief through some mechanism of influence, but it is the poor people who are the main

75. Consumer Protection, *Medical Negligence*, 12. Ibid.

> losers and have nowhere to go. The situation calls for immediate redressal and rejuvenation of the law of torts.[76]

The law of torts needs to be revived in Pakistan, as the author claims, not only for medical negligence, but also for many other civil wrongs to which the ordinary people of Pakistan are subjected on a daily basis. It was due to this reason, or at least one major reason, that India sought remedies against medical negligence through consumer law. We may now turn to this effort of the Indian Supreme Court.

1.4.3 India and the New Role of Consumer Law in Medical Negligence

The different problems and the remedies that we have discussed above all existed in India about four decades ago. Bogged down by a sluggish or rigid tort law system, as discussed in the case of Pakistan above, India decided to change course turning to consumer law. From another perspective, due to its inexpensive health care services,[77] India started becoming a popular destination for what has come to be called "medical tourism" being second only to Thailand.[78] Revenue from this source exceeded $2 billion by the year 2012.[79]

On paper, Indian laws comensate the patients, and also punish medical professionals who commit malpractice. India had relied on medical associations and hospital authorities to impose accountability and standards under mechanisms like criinal prosecution and self regulatroy system.[80] However, in reality delays in civil litigationis very common and criminal prosecution for medical malpractices is very

76. Warda Yasin, "Failure of Tort Law in Pakistan," *Pakistan Law Journal*2015, no. 4 (2015): 109-110.

77. Aaditya Mattoo & Randeep Rathindran, "How Health Insurance Inhibits Trade in Health Care," *Health Aff*.25

78. Nathan Cortez, "Recalibrating the legal risks of cross-border health care," *Yale J. Health Pol'y L. & Ethics*10 (2010): 22.

79. Ibid.

80. Ibid., 23.

rare.[81]So, in India there remained a gap between(in several well-intentioned) laws and their implementaions.[82]

Indian Parliament passed the Consumer Protection Act In 1986.[83] This statute was enacted to give practical shape to the United Nations Consumer Protection Resolution of 1985.[84] It took so much time to explain that the same Law isuseful to medical malpractice cases as well. In 1995, the Indian Supreme Court confirmed this decision in the landmark case of *Indian Med. Ass'n v. V.P. Shantha.*[85] Since the law hasturn into the most effecctive and well recognized law among medical consultants in India. So, the Law has become a matter of concern for doctors because it attempts to speed up the protracted civil litigation system, which is notorious for its delays and makes plaintiffs wait for decades.

Acording to the Act, there are three levels of consumer forums: district, state, and national. Those(at least) 604 District Forums and 34 State Commissions are the less costly and quicker alternatives to civil litigations where elected members with judicial and non-judicial backgrounds make decisios under the law of torts.[86]The complaints are heard on the basis of damages claimed by each forum within its original jurisdiction.[87]Both the State and National Commissions also have appellate jurisdiction to hear appeals from subordinate forums.[88]

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81. Ibid. 24.
82. Ibid.
83. Ibid.
84. Ibid.
85. A.I.R. 1996 S.C. 550.
86. Cortez, "Recalibrating the legal risks of cross-border health care," 25.
87. Ibid. 24.
88. Ibid. 25.

The Indian Parliament has empowered these forums to function more like courts, while removing the burden of too many procedural formalities that result in delays.[89] Thus, Indian parliament has created shortened procedures for speedy proceedings of those consumer forums. According to the Act, the limittation is two years to file a complaint from when the cause of action arose.[90] Forums are required to resolve issues within three months from the time they receive the defendant's response with a maximum of six months. In practice, however, cases are taking much longer.[91]

There are many problems that create hurdles for proving negligence. Among these are the easy availability of expert witnesses for physicians, but not for the patients alleging negligence.[92] Majority of qualified medical experts are not willing to attest that a teammate is negligent.In disputes, the hospitals and physians make it rather difficult for patients to get medical records from them.[93]Some observers have also expressed their doubts that consumer forums do not have the mandatory resources or skill to handle difficult medical cases.[94] In addition to the above issues, the compensation awarded may not be high enough for Western patients who visit India for treatment. Nevertheless, it is might be adequate for Indian patients, and the awards will increase as more experience is gained.[95]The forums have been empowered by the

89. See, e.g., The Consumer Protection Act, 1986, 13 and 17.

90. Ibid. Section 24.

91. Ibid. "The Department of Consumer Affairs estimated that only 27% of cases were resolved within the three-month period required by the Act." "Consumer Laws Implementation,"

92. Anoop K. Kaushal, *Medical Negligence and Legal Remedies* (2004), 2 as quoted by Cortez, "Recalibrating the legal risks of cross-border health care," 28.

93. Ganapati Mudur, "Indian Doctors Not Accountable, Says Consumer Report," *Brit. Med. J.* 321 (2000): 588.

94. Ramesh Bhat, "Regulation of the Private Health Sector in India," Int'l J. Health Plan & Mgmt. 11 (1996): 253, 262.

95. Ibid.

CHAPTER 2
CONSUMER LAW AND MEDICAL MALPRACTICE: HOW THE SYSTEM WORKS?

2.1 Introduction

In the previous chapter, the development of medical negligence law was traced briefly. After identifying the meaning of medical negligence and malpractice, the meaning of "medical professional" was examined, because it is the negligence of the professional that is termed "malpractice." The constitutional and international standards were noted and then the remedies available to patients or those who have suffered injuries were examined in general. The remedies available in Pakistan were also referred to in general terms and it was then stated that Pakistan is moving towards the Indian model of granting relief to patients in cases of medical negligence through the consumer law, with the lead being taken by Punjab.

The Consumer Courts in Punjab (Pakistan) have gradually started providing relief, under the Punjab Consumer Protection Law 2005, to patients who have suffered damages.[98] In this chapter, we will first examine in detail the broad features of this law, and how it operates within the province of Punjab. This will include the study of the various authorities proposed to be set up under this law. The major issues that are likely to create obstacles need to be pointed out too, without being overly critical. The types and nature of damages awarded for medical malpractice cases will be analyzed. The working of the Pakistan Medical and Dental Council will also be taken up.

98. See, e.g., http://pakistancriminalrecords.com/tag/medical-negligence/, and "Liver Damage: Consumer Court Orders Doctor to Pay Millions," http://www.dawn.com/news/1199727 (accessed August 30, 2015).

Before we do all this, however, it will be appropriate to examine briefly the state of recent legislation on consumer laws along with some earlier statutes that pertain to consumers. It may be mentioned here that describing the Punjab law, or the laws of other provinces or of Islamabad in isolation will not mean much. The corresponding or parallel provisions of the Indian Consumer Act, 1986 may be referred to wherever deemed necessary. This will bring out the advantages, in any, of the law applied in the Punjab.

2.2 Consumer Rights and Consumer Law in India

Rulers have always been concerned with the plight of the consumer. Consumer protection used to be the major concern of all the governments, because it was the satisfied consumer who ensured the survival of the government. Thus, even during Muslim rule, a large number of units of weights were used in India.[99] During the Sultanate period, the fixedprices were introduced by local conditions prevailing in the area.[100] Strict controls were established, for example, during the rule of Alauddin Khalji (1296-1316), a strict monitoring systemwas established for the market places.[101] There was a continuous chain of grain supply to the citiesduring those days and it was sold at prices fixed by the Sultan.[102] He determined a mechanism for price enforcement in the market where even shop-keepers were punished for selling sub-standard and under-weighing goods.[103]

99. Maulana Hakim Syed Abdul Hai, *India-During Muslim Rule* (Mohiuddin Ahmad trans., 1977), 127.

100. S.R. Bakshi, *Advanced History of Medieval India*, vol. 1 (Delhi: Anmol, 2002), 287.

101. Irfan Habib, "The Price Regulations 'Ala' Uddin Khalji—A Defence of Zia Barani," in *Money and the Market in India 1100-1700* (Sanjay Subrahmanyam ed., 1998) 88.

102. Ibid.

103. Ibid., 89.

This concern was carried forward by the British through a more or less uniform legal system. The important laws,concerning consumer interests,passed during the British rule are: "the Indian Contract Act of 1872",[104]"the Sale of Goods Act of 1930","the Indian Penal Code of 1860", "the Drugs and Cosmetics Act of 1940", "the Usurious Loans Act of 1918", and "the Agriculture Procedure (Grading and Marketing Act) of 1937."[105] These laws provided specific legal protection for consumers. For almost six decades, "the Sale of Goods Act of 1930"was the exclusive source of consumer protection in Pakistan. The Section 16 of the Act provides main protection from sellers for the buyer for defective goods.[106] It also provided exceptions to "the principle of Caveat emptor" ("let the buyer beware") and the interests of the buyer were also sufficiently protected. Section 16A has now imposed a duty on the seller to inform the buyer of defects, if any. This has been done to bring the law in line with Islamic injunctions. expressions such as "skill and judgment of the seller", "reliance on sellers' skill," and the test of "merchantable quality" provided effective remedies to buyers. Courts have been interpreting these rules in consumers' favor.[107]"The Sale of Goods Act 1930" was the exclusive legislation for consumers' protection in Pakistan until the consumer protection laws began appearing in 2003 (Baluchistan) and 2005 (Punjab). In India, the consumer protection law appeared earlier in the shape of the Consumer Protection Act of 1986. These consumer

104. It is called the Contract Act of 1872 in Pakistan. The Act has amended a few times, with the last important amendment being the change in the rule of *caveat emptor* as directed by the Federal Shariat Court.

105. The laws still apply with suitable amendments and the name Indian removed. Thus, the Sale of Goods Act of 1930, the Pakistan Penal Code of 1860, the Drugs and Cosmetics Act of 1940, the Usurious Loans Act of 1918, and the Agriculture Procedure (Grading and Marketing Act) of 1937.

106. . Sale of Goods Act, 1930 Section 16.

107. Gordon Borrie & Aubrey L. Diamond, The *Consumer, Society and the Law* (Harmondsworth: Penguin Books, Ltd., 1964), 66.

protection laws areintended to supplement the remedies, already provided, under the Sale of Goods Act.

The criminal justice system of Pakistan also have the provisions of consumer protection. False weights and measures, sale of adulterated foods and drink,sale of noxious food or drink and sale of adulterated drugs all deals within the provisions of Pakistan Penal Code of 1860.[108] Besides the punishment under "contract law" and "the criminal law", consumers also have rights under "tort law". But the law of tort, as a consequence of several legal intricacies, is not the best remedy for injured consumers in Pakistan.[109]Beside the Law of torts and contract, specific legislation needed to protect consumers rights.

In Western countries, where the law of torts is much more effective and efficient, the situation was much better, and the law has been providing more or less adequate remedies. Nevertheless, the consumer movement got a fresh boost in the 1960s. Consumer rights were not existed practically before 1960's. However, in 1962,U.S presidend Kennedy stressed upon the need of new consumer movement which lettar on resulted aconsumer bill of rights. This bill of rights introduced four basic points:

1. **Right to Safety**: Consumers have the right of protection against goods and services that have caused physical harm (excluding automobiles).
2. **Right to Information**: Accurate information is the right of consumers by the businesses that allowing them to make informed decisions about products and services.

108. See the Pakistan Penal Code, sections 264-67 and 272-76.
109. A. Rajendra Prasad, "Historical Evolution of Consumer Protection and Law in India," *Journal of Texas Consumer Law* 11 (2008): 132-36.

3. **Right to Choose**:There should be choice option for consumers to choose goods and services freely offered by various companies.

4. **Right to Be Heard**: If the Consumers have complaints and concerns regarding company practices and products there is right to be heard by the platform like the U.S. Attorney General, the Federal Trade Commission and so on represent only a few of the platforms in which consumers may be heard.[110]

By 1985, the United Nations expanded the Consumer Bill of Rights to include four points:

1. **Right to Basic Needs**:It is necessary for consumers to have access to food, water, clothing, shelter, healthcare, education, sanitary living conditions, and so on.

2. **Right to Redress**:If there any claim or fault found by a consumer in goods and services there is a right of redressal.

3. **Right to Consumer Education**: Information about goods and sevices must be provide to consumers by knowing there basic right and way to utilize them.

4. **Right to a Healthy Environment**: Healthy and working enviorment is a requirment of conusmers for the well being of them and their dependents as well.[111]

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110. While this Bill of Rights provided ground breaking protection, the U.S. Department of Justice and the Federal Trade Commission continued to establish new laws to protect consumer credit rights. Some of the primary consumer laws have included: Truth in Lending Act (TILA); Fair Credit Reporting Act (FCRA); Fair Credit Billing Act (FBCA); Fair Debt Collection Practices Act (FDCPA); Fair Credit and Charge Card Disclosure Act (FCCCA); Consumer Credit Reporting Reform Act (CCRA); Fair and Accurate Credit Transactions Act (FACTA); Credit Repair Organizations Act (CROA); Credit Card Act (CARD); and Dodd-Frank Wall Street Reform and Consumer Protection Act. For all these details see "A History of Consumer Rights and Improvements," at https://www.lexingtonlaw.com/blog/credit-repair/history-consumer-rights-improvements.html (accessed August 25, 2015.

111. Ibid.

CHAPTER 2: CONSUMER LAW AND MEDICAL MALPRACTICAL HOW THE SYSTEM WORKS

It was the persuasion of the United Nations that led to the passing of the the Consumer Protection Act of 1986 in India. The objective of this Act was to provide "cheap, simple and quick justice to Indian consumers." The Indian legal system, it is said, experienced a revolution with the enactment of the Consumer Protection Act of 1986.[112] It was intended to provide justice that was less formal, involving less paper work, less delays and less expense.[113] The Consumer Protection Act has received wide recognition in India as the poor man's legislation, which ensures easy access to justice.[114] The real revolution came when the Act came to be applied to medical negligence.

Prior to the Consumer Protection Act of 1986, patients injured by medical malpractice in India can now seek redress in one of two venues: sue in a consumer forum or sue in civil court.[115] Suing in a civil court is not much of an option.[116] Plaintiffs can sue for malpractice in India's civil courts under the "Fatal Accidents Act", which pay damages to the families of those killed by an "actionable wrong", defined as death caused by a "wrongful act, neglect, or default."[117] The survivals can sue in civil court for common law negligence.[118] This claims require plaintiffs to establish duty, breach, causation, and damages under tort law.[119] Indian courts also follow English precedents, and one of these is the well-known*Bolam* decision that helps courts to determine the standard of care.[120]The*Bolam* line of cases require courts to defer totally to the views of medical experts when determining the proper standard

112. Prasad, "Historical Evolution of Consumer Protection and Law in India," 134.
113. Ibid.
114. Ibid.
115. Cortez, "Recalibrating the legal risks of cross-border health care," 23.
116. Ibid. 35-36.
117. The Fatal Accidents Act, Section 1A, (No. 13 of 1855).
118. Cortez, "Recalibrating the legal risks of cross-border health care," 35.
119. Ibid.
120. Bolam v. Friern Hosp. Mgmt. Comm., [1957] 1 W.L.R. 582, 593 (Q.B.).

of care in each case.[121] *Bolam* andits progeny have neutered Indian courts, making it rather hard for plaintiffs to prove medical negligence. Civil litigation in India is also notorious for its interminable delays. "Plaintiffs may wait ten, twenty, or even twenty-five years for cases to conclude. Such delays undoubtedly deter many would-be plaintiffs. Authors have documented other reasons why India's civil courts are inhospitable to medical malpractice claims,95 and in aggregate, these obstacles make it difficult for plaintiffs to recover in civil courts."[122] The second avenue for medical malpractice in India is to file a complaint in its consumer forums, also known as Consumer Disputes Redressal Agencies (CDRAs).[123] India originally created its consumer forums as an alternative to civil courts in general, not as a venue for resolving medical malpractice claims. India's Consumer Protection Act of 1986 actually implemented the United Nation's Consumer Protection Resolution of 1985, which called for signatories to strengthen their consumer protection laws and enact "measures enabling consumers to obtain redress."[124] The Resolution was aimed at developing countries like India. A major goal of both the Resolution and the Act was to create a more accessible, realistic alternative for adjudicating consumer grievances, like complaints for receiving defective goods or services. No one expected consumer forums to become the main avenue for adjudicating medical malpractice disputes.[125]

At first it was unclear whether the consumer forums even had jurisdiction to hear medical malpractice cases.[126]The forums began hearing general consumer complaints

121. Bolam, 1 W.L.R. at 593.
122. Nathan Cortez, "Medical Malpractice Model for Developing Countries, A," *Drexel L. Rev.* 4 (2011): 230.
123. Ibid. 231.
124. G.A. Res. 39/248, U.N. Doc. A/RES/39/248 (Apr. 16, 1985).
125. Nathan Cortez, "Medical Malpractice Model for Developing Countries, A," *Drexel L. Rev.* 4 (2011): 231.
126. Ibid.

in 1987,but it was not until in 1992 that the "National Consumer Disputes Redressal Commission" confirmed that the medical services were also covered by the Act. It took another three years for the Indian Supreme Court to confirm this interpretation.[127] Since then, the medical community in India has become intimately familiar with the Act, frequently citing it as a "source of anxiety."[128] This is how the consumer law became the major avenue for medical negligence and malpractice cases. Medical malpractice plaintiffs typically file complaints for "deficient" medical services, defined as "any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance."

Generally medical service includes the service rendered by the hospitals (both government and private), nursing homes, health centers, clinics medical practitioners (physicians, surgeons, and these practitioners like ayurvedic, homeopathic or any other systems of medicine or surgery), chemist, diagnostic centers, paramedical staff, nursing, staff and other allied staff. According to the *New International Webster's Comprehensive Dictionary* of the English language, "doctor means a qualified practitioner of medicine or surgery in any of its branches" and "patient means a person undergoing treatment for disease or injury".

It is in this background that Pakistan adopted the consumer law followed successfully in India. The laws passed and adopted will be described briefly in the next section. Our focus in these laws, in the next section, will be on the meaning of "services," as medical negligence and malpractice fall in this category.

127. See Indian Med. Ass'n v. V.P. Shantha, A.I.R. 1996 S.C. 550.
128. Sanjay Kumar, "India: Doctors Dispute Trader Role," *Lancet* 340:(1992) 1400.

2.3 Consumer Law Legislation: Acts and Rules

Following the United Nation's 1985 Consumer Protection Resolution, which called for signatories to strengthen their consumer protection laws and enact "measures enabling consumers to obtain redress,"[129] and the subsequent success of the consumer movement in India through the Consumer Protection Act, 1986, there were stirrings in Pakistan too. Although consumer societies had been in existence earlier,[130] it was after the successes in India that awareness increased and various bodies started emerging within the civil society.[131] It is interesting to note, however, that most of these bodies have emerged after the Islamabad Consumers Protection Act of 1995.

In general terms, the situation about consumer rights and laws protecing these rights was almost similar to India. Thus, what has been said above about the Contract Act, the Sale of Goods Act, as well other laws, applies *mutatis mutandis* to Pakistan too. Consumer protection in Pakistan is a provincial subject. Accordingly, the Federal Territory as well as all four provinces have passed consumer laws. The Sindh government, however, issued an Ordinance called the Consumer Protection Ordinance, 2007. This Ordinance lapsed after the expiry of its legally prescribed period and was not revived or converted into an Act. All other Provinces have passed laws with the objective, as in the Indian law, to provide simple, speedy and cheap

129 G.A. Res. 39/248, U.N. Doc. A/RES/39/248 (Apr. 16, 1985).

130 For example, the Punjab Cooperative Consumers Society (CO-OP), which was the later version of the the West Pakistan Cooperative Consumers Society (COOP) established in October 1962 with financial and technical help of Government of Denmark. This, however, was more of a marketing organization. It was not concerned with the promotion of consumer rights.

131 The Consumer Rights Commission of Pakistan (CRCP), a rights-based civil initiative registered under the Trust Act, 1882, was established in 1998. CRCP is an independent, non-profit, and non-governmental organization. It has done considerable work in promoting consumer rights and spreading awareness (See http://crcp.org.pk/). Another, later organization is the Consumers Association of Pakistan (CAP), which was formed on 13th September 2003 (See http://cap.org.pk/).

procedures for the redressal of the grievances of consumers. The following laws have been passed and are currently effective and applied:

1. The Islamabad Consumers Protection Act, 1995.
2. The Islamabad Capital Territory (Consumers Protection) Rules, 2011.
3. The Khyber Pakhtunkhwa Consumers Protection Act, 1997.
4. The Balochistan Consumers Protection Act, 2003.
5. The Punjab Consumer Protection Act, 2005.
6. The Punjab Consumer Protection Rules, 2009.

Some of the other laws that may be mentioned here, as they directly affect the rights of consumers, are given below:

1. The Telecom Consumers Protection Regulations, 2009.
2. Pakistan Electronic Media Regulatory Authority (Distribution Service Operations) Regulations, 2011.
3. The Sale of Goods Act, 1930.
4. Pakistan Standards and Quality Control Authority Act, 1996
5. Drugs Act, 1940
6. Drugs Act, 1976
7. Pakistan Penal Code, 1860

CHAPTER 2: CONSUMER LAW AND MEDICAL MALPRACTICAL HOW THE SYSTEM WORKS

The Consumer Courts set up in the Province of Punjab, under the law mentioned above, are the most active as compared to the other provinces.[132] These Courts are trying to give relief to the consumers as cases arise. The Lahore High Court has also given several judgements under the new law, but it is too early for significant judgements that will shape the new law. Accordingly, it is the Punjab Consumer Protection Act, 2005 that we will take up to describe the procedures and the legal structure created. There is some activity now in the Province of Khyber Pakhtunkhwa as well. It is obvious that the laws implemented in the povinces have some major structural and procedural differences, and the laws are being applied in different ways, but that is beyond the scope of this study.

As this study is concerned primarily with medical negligence and malpractice, it is necessary to see how it is covered under the above laws. This may be done by considering the definition of "services" under these laws, as medical negligence arises out of the "medical services" provided to consumers. The provision of medicines and other medical products may fall under "goods," but we will not concern ourselves with that in this study, although there may be a dire need to look into that area from other perspectives. In addition, our focus in this study is on doctors as "professionals," and we will not concern ourselves with the profession of nursing and of paramedics directly. Nursing staff, paramedics, medicines, and other things may, however, be covered under the general term of "medical services" provided by hospitals.

132. See the website of the Consumer Protection Council for a summary of these decisions, at http://pcpc.punjab.gov.pk/?q=dcdecisions (accessed August, 2015).

Section 2(k) of the Punjab consumer Protection Act 2005[133] defines the term "services" as follows:

> "services" includes the provision of any kind of facilities or advice or assistance such as *provision of medical,* legal or engineering services but does not include—
> (i) the rendering of any service under a contract of personal service;
> (ii) the rendering of non-professional services like astrology or palmistry; or
> (iii) a service, the essence of which is to deliver judgment by a court of law or arbitrator.[134]

It can be seen from this definition that the term "services" includes "medical" services. This eliminaties the need for what happened in India, because initially the law there was unclear whether the consumer forums even had jurisdiction to hear medical malpractice disputes.[135] It was only when the "National Consumer Disputes Redressal Commission" declared in 1992 that the Act covered medical services but it took another three years by the Indian Supreme Court to confirm this interpretation.[136] The Punjab law, by mentioning the word "medical" in the definition of the term "services" has preempted this issue. Consequently, the consumer courts are hearing cases of medical negligence and defective or deficient services provided by doctors and hospitals.

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133. See Punjab Consumer Protection Act, 2005, section 2(k) (emphasis added). Section 2 deals with "definitions."

134. Ibid.

135. Nathan Cortez, "Medical Malpractice Model for Developing Countries, A," *Drexel L. Rev.* 4 (2011): 230.

136. See Indian Med. Ass'n v. V.P. Shantha, A.I.R. 1996 S.C. 550.

As compared to this, section 2(n) of the Khyber Pakhtunkhwa[137] law defines the term "services" as follows:

> "Services" includes services of any description which are made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, manufacturing, processing, accountancy, supply of electrical, mechanical or any other form of energy, boarding or lodging, entertainment, *medicine*, education, construction work, amusement, catering, security, or purveying news or other information and similar other services, but does not include the rendering of any service free of charge or under the contract of personal services;[138]

Thus, this definition too reads that "Services" includes "services of any description which are made available to potential users and includes the provision of facilities in connection with ...*medicine*, ..." Here too, there is no need for the High Court or another body to interpret the law to inlcude cases of medical negligence. In Khyber Pakhtunkhwa, however, there has been delay in setting up separate consumer courts. Initially the powers were given to the District judges. It was only last year that consumer courts were set up, and that too at the divisional level alone; the courts at the district level could not be set up due to financial constraints, as claimed by the government.[139]

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137. See the Khyber Pakhtunkhwa Consumers Protection Act, 1997, section 2(n) (emphasis added). The law was amended substantially through an amending Act of 2005.

138. Ibid.

139. Available at http://www.thenews.com.pk/Todays-News-7-229429-KP-govt-approves-PHC-summary-on-consumer-courts(accessed August, 2015).

The law in Balochistan is almost a copy of the Khyber Pakhtunkhwa law. Thus, the term "services" is defined in an identical way with the same meaning.[140] The definition of the term "services" used in these two Acts has in turn been taken from the Islamabad Consumers Protection Act, 1995. Section 2(e) of this law defines the term services as follows:

> "Services" includes services of any description which is [sic] made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, manufacturing, processing, accountancy, supply of electrical, mechanical or any other form of energy, boarding or lodging, entertainment, medicine, education, construction work, amusement; catering, security, or purveying a news or other information, and similar other services, but does not include the rendering of any service free of charge or under the contract of personal service;[141]

The situation then may be summarised as follows:

> Punjab stands out among the four provinces for setting up exclusive courts for hearing the complaints of consumers. These courts are providing relief to the consumers in a large variety of cases Sindh in contrast does not have laws for the consumer protection, because the Ordinance of 2007 lapsed and was not revived. Balochistan has passed the legislation, but is yet to set up any court. In Khyber-Pakhtunkhwa

140. See the Balochistan Consumers Protection Act, 2003, section 2(n).
141. The Islamabad Consumers Protection Act, 1995, section 2(e).

(KP), district and session judges had been given the additional charge for dealing with the consumer-related complaints as no separate court had been made by the previous government. Courts at the divisional level were set up in 2014, but the districts are waiting for their courts. In Islamabad, additional district and session judges have been given this charge. Given the load of criminal and civil cases, these courts cannot deal effectively with the consumers-related complaints.[142]

The above analysis, shows that cases of medical negligence can be filed in the three Provinces as well as in the Islamabad Capital Territory, but a proper infrastructure exists only in the Punjab. In the other jurisdictions, exclusive consumer courts have either not been created or are not fully functional as yet.

2.4 The Punjab Consumer Protection Act, 2005, and Rules 2009

The Punjab Consumer Protection Act, 2005, unlike the Indian law of 1986 included medical services within the meanin of services as defined in section 2(k). It, therefore, did not have to go through the process of inclusion. The Act obviously relied on the Indian experience. The Act provides the definitions of the various terms used in the Act. Some important definitions having a bearing on services rendered by medical profession. The meaning of medical services has been discussed above, but the words "services includes the provision of any kind of facilities or advice or assistance" do not mention or do not attempt to exclude services that are "free" or "gratis." We may

142. For these and other details see http://www.thenews.com.pk/Todays-News-2-142956-Consumer-courts-providing-relief-to-people (accessed August 2015).

devote a small section to this term as the law may need to clarify this later or through amendment.

2.4.1 Free Service and Service for a Consideration

The law in India made a distinction between services for a charge and service without a charge.[143] It does not include free services under the consumer law, that is, a complaint under the consumer law where service provided were free of charge, cannot be made under this law. The term "service free of charge," however, has not been defined under the Act. The Indian Supreme Court has, therefore, through several decisions sought to make this clear by stating that the medical practitioners, Government hospitals/nursing homes and private hospitals/nursing homes broadly fall into three categories:

> The medical practitioners, Government hospitals/nursing homes and private hospitals/nursing homes broadly fall into three categories:
> (1) where services are rendered free of charge to everybody availing the said services,
> (2) where charges are required to be paid by everybody availing the services, and
> (3) where charges are required to be paid by person availing services but certain categories without any charge. In the case of doctors and hospitals, who render services without any charge, such services do not fall within the ambit of "service" under section 2(1)(O) of the Act.[144] The payment of a token amount for registration purposes

143. The Consumer Protection Act, 1986 (India).
144. That is, the Consumer Protection Act, 1986 (India).

only, would not alter the position in respect of such doctors and hospitals.[145]

According to the State Commission Delhi,[146] Karnataka,[147] Madras,[148] Punjab[149] Rajasthan[150] Maharashtra[151] and Madhyapradesh,[152] the patient availing of the facility of medical treatment in a hospital run by the Government is not a consumer. It was only the State Commission of Orissa that held that "the services rendered by the doctors free of cost in Government hospitals are within the scope of scrutiny by the consumer Forum".[153] The National Commission[154] and Supreme Court in "*Indian Medical Association v. V.P. Shantha*"-"*AIR 1996 SC 550.*" held that:"the services rendered by the medical practitioner or hospital or nursing home free of charges fall outside the expression "services" defined in section 2(1)(O) of the Consumer Protection Act".

As stated above, the Punjab Consumer Protection Act, 2005 by stating that "services includes the provision of any kind of facilities or advice or assistance" does not mention or does not attempt to exclude services that are "free" or "gratis." Does this mean that the medical practitioner or hospital or nursing home providing services free of charges falls within the expression "services" defined in section 2(k) of the

145. A.C. Modagi v. Cross Well Tailor and others, 1991(2) CPR 432 1, (1991) CPJ 506(NC); Kasturi Bhattargee v. Sivaji Basu and Others, (1997) CPJ 575.
146. Smt. Ran Kali v. Delhi Administration 1(1991) CPJ 309 (Delhi).
147. Sowbhagya Prasad v. State of Karnataka (1) 1994 CPJ 402.
148. Kadarkari Nadar v. Rakkappan 1994(1) CPR CPR 359(Mad).
149. Pavitas Singh v. State of Punjab (1994) CPJ 397
150. Hanuman Prasad Darbun v. Dr.C.S. Sharma 1991 (1) CPR63 (Bombay).
151. Lexman Thanappa Kotgiri v. Union of India, 1998 CC 1093 (Bombay).
152. G-Smt. Rajbai v. Madhya Pradesh Shasan Sanchiv Lok Swathya Avan pariwar Kottayam Vibhagi, (1999) CPJ 578(Bhopal).
153. Govind Chanda Mohanty v. .Director Medical and Health Services, II (1992) CPJ 890.
154. Consumer Unity and Trust Society, Jaipur v. State of Rajasthan AIR 1995 SC 1922.

Consumer Protection Act, 2005? The Act or the Rules framed under the Act do not clarify this point. This will mean that the government can be sued for providing defective services. This is like opening the door to the totious liability of the State and the Statutory Bodies, which is at present restricted. Section 3 of the Act says that the "provisions of this Act shall be in addition to and not in derogation of the provisions of any other law for the time being in force."[155] This provision may be used to oust liability of government institutions at least. Section 2(c)(ii), however, may prove more useful for this purpose. It says that a consumer is a person who "hires any services for a consideration and includes any beneficiary of such services." The words "hiring" and "consideration" ensure that the services are not free.

Another expression used is "contract of personal service", which is un-defined under the Act. In the literal sense, it means an agreement to provide services in a personal capacity to an individual. The common example used is that "a servant entering into an agreement with a master for employment, or where a landlord agrees to supply water to his tenant, these are the contracts of personal service". Here the contract is terminable at will and the master is not bound to continue the service. The question is whether a doctor in whom the patient has faith and feels confident in his skills can be called a contract of personal service. This is usually the case with doctors and lawyers and other professionals including teachers. The answer is no, these professionals are not excluded from the term services as used in the Act. The comparison is with the phrase "contract for personal service". The example, is that of a tailor who is asked to stitch a suit for hiw customer. Such a person is called an

155. Consumer Protection Act, 2005, section 3.

"independent contract," as compared to a servant. The independent contractor is not excluded from the definition of "service."

2.4.2 Who is a Consumer and Patient as Consumer

The meaning of the term consumer is essential as it is the consumer who will ultimately be injured in some way, and it is he who will be filing a complaint in the consumer court. Section 2 (c) of the Act defines the term "consumer" as follows:

> "Consumer"means a person or entity who–
> (i) buys or obtains on lease any product for a consideration and includes any user of such product but does not include a person who obtains any product for resale or for any commercial purpose; or
> (ii) hires any services for a consideration and includes any beneficiary of such services;
> Explanation:—For the purpose of sub-clause (i), "commercial purpose"does not include use by a consumer of products bought and used by him only for the purpose of his livelihood as a self-employed person.[156]

The meaning of "services" in the previous section to mean services that are not free combined with the definition here show that consumer is a person who hires services and is not one who avails of them free. The "services" rendered by private medical practitioner and private nursing homes and hospitals, government hospitals, health

156. Consumer Protection Act, 2005, section 2(c).

centers and dispensaries, if not free are covered within the definition of "services" and "the person who avails of the said services is a consumer".

This shows that a "patient" is one who hires "medical services" and he obviously hires them for a consideration. According to section 2(k) of the Act,the medical assistance for payment carried on bymembers of medical profession or hospitals falls within the scope of services and the persons who avail of such services is a consumer under the Act.[157] Consumer includes the legal representatives of the deceased consumer.

The words "any beneficiary of such services" is intended to include not only minors, but also the insane and incapacitated who are unable to enter into a contract on their own. Thus, "the definition of the term consumer is wide enough to include not only the person who hires the services but also the beneficiary of such services, whoever he may be".

2.3.3 Liability for Medical Negligence Arising Out of Defective and Faulty Services

The Punjab Consumer Protection Act, 2005 deals with product liability as well as liability for defective and faulty services. It is obvious that medical negligence or malpractice will fall under the provision of defective and faulty services. It is customary in the law of torts to assess whether the provider of the service has been negligent. Negligence is obviously measured against some standard that the performance must meet. The minimum threshold varies from service to service and according to the skill of the provider. The concepts of "defect" and "fault" identified

157. Here it may be pointed out that the position is almost the same under the Islamabad Cosumers Protection Act, 1995 and the The Khyber Pakhtunkhwa Consumers Protection Act, 1997.

by the Act include "negligence," but are wider than negligence. In other words, negligence will always mean defect and fault, but defect and fault will not always mean negligence. The Supreme Court of India, in its landmark judgment given on November 13, 1995, in the case of *Indian Medical Association v V-P Shanta* held that patients, who received deficient services from the medical professionals and hospitals, were entitled to claim damages under the Consumer Protection Act 1986.[158] Before the Consumer Protection Act, 1986 came into existence the term "negligence" was used for dealing with failure or misdeeds of the doctors. In the Consumer Protection Act the term "deficiency" has been introduced and defined under Section 2(1)(g).[159] Likewise, the Punjab Conumer Protection Act, 2005 focuses on "defect" and "fault" and not on negligence. A whole chapter (sections 13 to 17) has been devoted to defective and the damage arising therefrom.[160] The Punjab Act does, however, mention negligence in section 31(e) in the context of compensation. The words are: "to pay reasonable compensation to the consumer for any loss suffered by him due to the negligence of the defendant."[161] This negligence has not been mentioned in the context of damages. Section 31(f) says: "to award damages where appropriate."[162]

In addition to the element about defect or fault in services, medical professionals like other professionals are expected to exercise or provide reasonable degree of care in treating patients. A medical practioner providing professional services for consideration is liable under the Act if he fails to meet the reasonable standard of care

158. (1995) CPJ 1 SCC.
159. Consumer Protection Act, 1986 (India).
160. Punjab Protection Act, 2005, sections 13 to 17 (Chapter on liability arising out of defective and faulty services).
161. Punjab Protection Act, 2005, sections 31(e).
162. Punjab Protection Act, 2005, sections 31(f).

and skills. Section 14 of the Act deals with such a standard. The main features or elements of liability due to defective services may be summarised as follows:

1. **Damage Must be Caused by Service:** Section 13 says that "A provider of services shall be liable to a consumer for damages proximately caused by the provision of services that have caused damage."[163] The damage caused must be proximate and not remote. This, of course, will be determined by the Court on the basis of expert testimony.

2. **Standard of Service Expected of a Medical Professional Must Have Been Maintained:** Section 14 states that "where the standard of provision of a service is regulated by a special law, provincial or federal, the standard of services shall be deemed to be the standard otherwise the standard laid down by a regulating body or the standard of reasonable care will be the standard. The performance of service must not have been below this standard, otherwise damage caused will be determined".[164]

3. **Damages Will be Awarded When Caused:** Section 15 places a restriction on the grant of damages, and says: "Where the consumer has not suffered any damages from the provision of service except lack of benefit, the service provider shall not be liable for any damages except a return of the consideration or a part thereof and the costs."[165] This means that where no damage has been caused only the benefit

163. Punjab Protection Act, 2005, section 13.
164. Punjab Protection Act, 2005, section 14.
165. Punjab Protection Act, 2005, section 15.

expected from the service has not been received, the award will be restricted to the return in whole or in part of the consideration.

4. **Duty Disclosure:** A duty of disclosure is imposed on the doctor where the medical treatment to be provided requires such disclosure. This is stated in section 16.[166]

5. **Liability Cannot be Evaded by Contract:** Section 17 says that "the liability of a person ...to a person who has suffered damage shall not be limited or excluded by the terms of any contract or by any notice."[167]

2.4.4 Consumer Protection Council

Section 24 of the Act provides for the setting up of District Consumer Protection Councils as well as a Provincial Consumer Protection Council. The Rules made under the Act in 2009 lay down the details about these Councils including membership.[168]Rule 21 lays down the following functions of the Council:

1. to gather such information and data as may be necessary in order to remove defective products and services from trade or commerce and submit reference to the Authority;
2. to examine the work being done by the District Councils and ensure that the District Councils are performing functions in accordance with the Act, rules and instructions of the Government;

166. Punjab Protection Act, 2005, section 16.
167. Punjab Protection Act, 2005, section 17.
168. Punjab Consumer Protection Rules 2009, Rules 19 to 21.

3. to review the reforms proposed by the District Councils, assess the feasibility for implementation of the reforms and suggest improvements;

4. advise theGovernment and Authority on matters relating to protection of consumers;

5. to increase awareness about consumer protection issues;

6. issue information booklets on standards of products and services in different areas of Pakistan and some selected areas of the world;

7. to establish and manage a laboratory for carrying out tests of the products or equipment of the services; and

8. to set guidelines and standards for the laboratories managed, recognized or registered by the Council.

The Provincial Consumer Protection Council now has a website "http://pcpc.punjab.gov.pk" from where it is coordinating and disseminating information.

2.4.5 Complaints and Simplified Procedures

Section 28 of the Act deals with the settlement of claims of consumers who have suffered damage. Section 29 provides for the procedure of settlement at pretrial stage after offer is made by a party to the dispute. The procedure to be followed by the Consumer Court on receipt of a complaint is outlined in section 30. Section 31 deals with the Order of the Court.[169]

169. Punjab Protection Act, 2005, sections 28 to 31.

2.4.6 The Consumer Courts and Types of Cases Settled

The Act provides, in section 25, " that a claim for damages arising out of contravention of any provisions of this Act shall be filed before a Consumer Court set up under the Act." Section 26 authorizes the Government to establish, by notification;"one or more separate Consumer Courts, for an area comprising one or more districts, to exercise jurisdiction and powers under the Act.[170] The Consumer Court shall consist of a District Judge or an Additional District Judge to be appointed by the Government in consultation with the Lahore High Court."

Section 27 determines; "the jurisdiction of Consumer Courts and says that subject to the provisions of this Act, the Consumer Court shall have jurisdiction to entertain complaints within the local limits of whose jurisdiction the defendant, at the time of filing of the claim, actually and voluntarily resides or carries on business or personally works for gain."[171]According to the Website of the Consumer Protection Council, the following Consumer Courts are functioning at present (as it appears on the Protection Council Website):

- Bahawalpur, House No.42/A Younas Road, Model Town Block A, Bahawalpur
    - D.G.Khan, Judicial Complex, D.G. Khan
    - Faisalabad, P-61 Jinnah Colony, Faisalabad
- Gujrat, House No.116-A, Shadman Colony, Near Shell Petrol Station, Gujrat
    - Gujranwala, Near DCO Office, Gujranwala
    - Lahore, 360 Riwaz Garden, Lahore

170. Punjab Protection Act, 2005, sections 25 to 26.
171. Punjab Protection Act, 2005, section 27.

- Multan, House No.430/17-B/XII, Near Chungi No.01, Waqas Town Pul Wasil Multan
- Rawalpindi, Old District Katchery, New Block, Special Court Complex, Rawalpindi
- Sahiwal, 36-C, Farid Town, Sahiwal
- Sargodha, Banglow No.10, House No.11, Opposite Circuit House, Civil Lines, Sargodha
- Sialkot, Cantt. View Colony, Near Police Top Khana Stop, Sialkot

It is obvious that these courts cater for more than one district. Taking just one year (2013), we see the following statistics for cases in the category of medical services: Medical Services/Doctor 95, Veterinary Services 0, Pharmaceuticals 22, Quack /Fake Doctor 0.[172] Medical Services/Doctor 617, Veterinary Services 3, Pharmaceuticals 11, Quack/Fake Doctor 150.[173] In 2012, the report was as follows: Medical Services/Doctor 117, Veterinary Services 0, Pharmaceuticals 1, Quack /Fake Doctor 36.[174] The decisions of the Courts have also been placed on the website and can be downloaded.[175] A few representative cases have been mentioned in the early part of this chapter.

2.4.7 The Role of Medical Experts

Rule 6(2) says:"In determining whether a service is defective because of lack of adherence to any professional or statutory standards or otherwise, the Authority may rely on the evidence of an expert or a panel of experts."[176]It is well known in tort and

172. http://pcpc.punjab.gov.pk/?q=system/files/dcc_fs_2013.pdf.
173. http://pcpc.punjab.gov.pk/?q=system/files/dcc_fs_2013.pdf.
174. http://pcpc.punjab.gov.pk/?q=system/files/dcc_fs_2012.pdf.
175. http://pcpc.punjab.gov.pk/?q=dcdecisions.
176. Punjab Consumer Protection Rules, 2009.

negligence cases pertaining to medicine that finding independent unbiased experts is a huge problem, because a doctor will usually follow his fraternity and support the doctor who has committed negligence. "[P]atients often struggle to secure their own medical experts in adversarial litigation. Expertise may be scarce or unaffordable. Physicians may be unwilling to testify against other physicians known as the 'conspiracy of silence.' In jurisdictions that require plaintiffs to prove negligence, this burden can be insurmountable without an expert who is willing to testify that the defendant breached the standard of care."[177] The consumer law system will have to overcome this obstacle in some way if system failure has to be prevented.

2.4.8 The Extent of Damages to be Awarded

Section 31 permits the payment of reasonable compensation and damages in the following words: "31(e) to pay reasonable compensation to the consumer for any loss suffered by him due to the negligence of the defendant; (f) to award damages where appropriate."[178] Section 15 attempts to restrict damages to cases where the consumer has suffered damages from the provision of service. In other words, damages will not be imposed where actual damage is not proved. The Act, however, does not impose a cap on the award of damages. This is a legislative tool used to respond to the large number of malpractice cases and the rise in health care costs. The legislatures impose statutory caps on damages awarded by the courts. Such caps make sense in countries like the United States where phenominal damages are sometimes awarded by courts. For example, in *Etheridge v. Medical Centre Hospitals*,[179] the jury returned a verdict to the amount of $2.7 million against two defendants whose

177. [80Cortez, "Medical Malpractice Model for Developing Countries," 227.
178. Punjab Protection Act, 2005, sections 31(e).
179. 376 S.E.2d 525 (1989)—Supreme Court of Virginia.

CHAPTER 3

CONSUMER LAW THE BEST OPTION FOR MEDICAL NEGLIGENCE?

In a landmark case, "the Lahore Consumer Court, on Monday 10th August 2015, ordered a doctor to pay damages to the tune of 212,267 pounds sterling (Rs33.963 million) and Rs 13.07m to a man for causing permanent damage to the liver of his new-born daughter in 2007." This case appears to similar in significance to the Indian case of medical malpractice, Dr. Balram Prasad v. Dr. Kunal Saha & Others, in which the Supreme Court of India imposed damages that are likely to touch more than 11 crores (equivalent to 20 crores in Pakistan). In the lahore case, the court found aformer dean of the Children Hospital, Professor Dr. Tahir Masood, the guilty of performance malpractice while treating Syeda Durr-e-Zahra who was the daughter of Syed Ali Murtaza, a government official. The babylived, but after liver transplant in the United Kingdom.[181]

181. Wajih Ahmad Sheikh, *Liver damage: Consumer Court orders doctor to pay millions in damages*. Available athttp://www.dawn.com/news/1199727. For more details, see also Consumer courts Available at http://www.thenews.com.pk/Todays-News-8-333708-Consumer-courts.(accessed July 27, 2015).

The above case, and many others reported on the website of the Consumer Protection Council,[182]do give the impression that the consumer courts may provide a satisfactory solution to the plight of the patients and the deplorable state of health-care. A news report, thus, states: "The consumer court, if it can effectively deal with cases of medical malpractice, could be a way out of a sticky situation for both doctors and patients."[183] The report goes on to state, however that the "trouble is that using consumer courts is far from an ideal mechanism."[184] The cause identified for the trouble is that there is only one consumer court in Lahore, which is currently congested with over 1000 cases. The judge was also reported as being forced to divide time between four different district consumer courts. The report also says that in "Khyber Pakhtunkhwa, consumer's courts were created in 2014 with seven judges assigned to oversee consumer infringements in seven divisional headquarters. The Kohat court was reported to have received over 100 complaints in its first few months."[185] The Provincial Sindh Assembly has also approved consumer courts in February 2015. The report concludes: "This may not be the best mechanism, but some relief may be available now to the many who have suffered from medical malpractice."[186]

This is exactly the burden of this chapter. The consumer courts, though not the best mechanism, are definitely providing some solution for medical negligence problems. Nevertheless, is this the only model for resolving the problem of medical negligence? Should we gradually move to a better system? If so what? What options are available

182. http://pcpc.punjab.gov.pk.
183. Consumer courts Available at http://www.thenews.com.pk/Todays-News-8-333708-Consumer-courts.(accessed July, 2015).
184. Ibid.
185. Ibid.
186. Ibid.

in the world, out of which we may be able to adopt the better option? To answer these, and similar, questions, we need to have a look at some of the models available in the world today.

3.1 The Global Market for Patients and Health Care

> The United States spent $255 billion in 1980 while $1.9 trillion in 2004 and more than $4 trillion per year by 2016.[187] So, U.S. health care spending increased from 9%of GDP in 1980 to 16% in 2004. The position in other advanced countries, especially those in Europe, is no different. This is giving rise to what is being called "Medical Tourism."[188]

Each year, an increasing number of patients leave the United States for medical care in search for less expensive services. They travel to developing countries for different sophisticated and complex treatments, such as heart surgeries, joint replacements, and fertility treatments.[189] In doing so, they choose to pass by the legal and regulatory protections, and perhaps even insurance coverage that they receive in their developed, but expensive home countries.[190] Thus, patients are waiving the rights,

187. National Health Statistics Group, Centres for Medicare and Medicaid Services (CMS), Table. 1, available at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf. See also http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf. (accessed September, 2015).

188. Nathan Cortez, "Patient without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care," *Indiana Law Journal* 83 (2008): 71.

189. Ibid.

190. Ibid., 72.

benefits, and protections offered by this expensive but advanced health care regulatory system to seek medical care in countries that may not grant them remotely similar rights or protections.[191] The WTO sees medical tourism as a way to improve the global supply-demand imbalance in health care.[192] The World Health Organization calculates medical tourism will grow with developed countries.[193] The World Bank found that the United States could save billions. Senate held hearings to discuss whether medical tourism can reduce health care spending.[194]

The main idea behind the above discussion is to show that not only can the rich countries cut down their health care costs by sending their patients abroad, huge benefits can flow towards the less developed countries who have lesser developed health care systems. There is a growing consensus that the tendency of sending patients abroad may have an effect on the health care systems in both developed and developing countries. In fact, more and more patients, an increasing number of employers and insurers are exploring opportunities to reduce spending by using foreign health care providers.[195]

The above developments show that Pakistan, which has a reasonably good health care system, a system that can be developed and improved

191. Ibid.

192. See *WTO Agreements and Public Health: A Joint Study by the WHO and WTO Secretariat* (2002), 111-124, available at http://www.wto.org/english/res-e/booksp_e/who-wto-e.pdf.(accessed September, 2016).

193. Rupa Chanda, "Trade in Health Services" (Commission on Macroeconomics and Health, World Health Org., Working Paper Series, Paper No. WG 4:5, 2001), 7.

194. *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the Senate Special Committee on Aging,* 109th Cong. (2006).

195. Ibid.

further with many benefits flowing to the profession as well as to the country as a whole. Pakistan must, therefore, pay immediate attention to the improvement of its health care system and professional medical services. In addition to the development of the health care system, the best medical negligence model needs to be adopted not only for the sake of the domestic needs, but also for generating and inviting foreign interest in the health care system. Some of these models are now considered below.

3.2 The Various Models for Medical Negligence

When the discussion of medical negligence and malpractice litigation is undertaken, the major focus is on developed countries like the United States, the United Kingdom, and sometimes Europe. The systems prevalent in the developing world are almost never discussed. It is generally acknowledged that developing countries account for more than 80% of the world's population, but they are not given the importance they deserve in comparative health law literature.[196] Many important comparative compilations rarely discuss the situation prevailing in developing countries. The focus in well-known books on the international medical malpractice is mostly on wealthy, developed countries like the United States, Great Britain and Germany.[197]

196. See Barbara McPake & Anne Mills, "What Can We Learn from International Comparisons of Health Systems and Health System Reform?" *Bulletin of World Health Organization*78: (2000) 811, 817, available at http://www.who.int/bulletin/archives/78(6)811.pdf.(accessed Oct, 2015).

197. The best known book in the field may be quoted as an example. This is: Dieter Giesen, International Medical Malpractice Law: A Comparative Law Study of Civil Liability Arising from Medical Care (1988).

CHAPTER 3: CONSUMER LAW THE BEST OPTION FOR MEDICAL NEGLIGENCE?

Developing countries, it is said, do not have the luxury of worrying about medical malpractice,[198] but malpractice in developing countries is considered worth examining these days due to several reasons. First, "patients from the United States and other Western countries increasingly live in or visit the developing world and consume health care there."[199] The second reason is that it needs to be appreciated how medical malpractice law operates and evolves in different environments. Thus, developing countries may utilize legal and regulatory models that look nothing like those followed in developing countries.[200] Although some jurisdictions follow Western modelsas in the case of India' and now Pakistan, the systems function differently in practice.[201] Further, developing countries have very different health care systems where health insurance is less common, while cash transactions and other out-of-pocket payments predominate.[202] It is for this reason that writers like Nathan Cortez and others have started studying these other models so that patients visiting these countries may have adequate information about how these jurisdictions handle medical malpractice disputes and the obstacles patients might encounter.[203]

Writers consider two major models prevalent in developing countries. The first is that adopted by India, and now being followed in part of Pakistan. The second is the model being followed in Mexico, which follows the civil law unlike common law in India. We will discuss the main features of these two models as they are presented by

198. Nathan Cortez, "Recalibrating the Legal Risks of Cross-Border Health Care",*Yale Journal of Health Policy, Law & Ethics* 10:(2010), 1.

199. Cortez, "Medical Malpractice Model for Developing Countries, A", 218. By way of example, he mentions the following sources too: Nicolas P. Terry, "Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing," *Western New England Law Review* 29:(2007), 421; I. Glenn Cohen, "Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument," *Iowa Law Review* 95:(2010), 1467; and [71]cortez2008patient.

200. Cortez, "Medical Malpractice Model for Developing Countries, A," 218.

201. Ibid.

202. Ibid.

203. Ibid.

experts in the field. Before doing so, we will identify the features that beset the developing nations and not the developed countries.

3.3 Distinctions between Developing and Developed Jurisdictions

The evaluation of the models in India and Mexico is meaningful only when it is appreciated how much developing countries can differ from developed countries and why these differences matter. The problems that beset the developing countries are usually "poverty, infectious diseases, professional shortages, underdeveloped health systems, weak infrastructure, large informal economies, regulatory and civil society deficits, and other problems that tend to be secondary (if they exist at all) for most developed countries."[204] The significance of these factors will be discussed below in brief. The main purpose is to show that unless these adverse factors are removed, developing countries will not be able to adopt those models that are followed or implemented in the developed countries.

3.3.1 Poverty

The dearth of capital and money is an obvious but important distinction between developed and developing countries.[205] Developing countries struggle with poverty and resource constraints in a way that developed countries simply do not.[206] These fiscal realities limit what they can spend on health care and health infrastructure, thus, affecting the quality of care provided.

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204. Ibid.220.

205. In fact, the very term "developing country" is used to denote low or middle-income countries, or both.

206. Hasna Begum, "Poverty and Health Ethics in Developing Countries," Bioethics 15:(2001), 50.

3.3.2 Health Priorities Due to the Prevalence of Infectious and Other Diseases

Poverty is the common factor in developing countries like Pakistan, India, China, and African nations sothey have their own health policy priorities to relegate patients' rights to a secondary or even tertiary concern. Some diseases like HIV/AIDS, malaria, SARS, polio (in Pakistan), and other infectious diseases are common and endemicin these countries.[207] This rightly diverts funds from things like medical negligence to addressing public health crises.

3.3.3 Scarcity of Physicians

Most developing countries struggle with very low ratios of health care professionals to the general population, which contributes to the reluctance to over-regulate them. The World Health Organization (WHO) identified fifty-seven countries that face crisis-level shortages of health care professionals, many of which are low-income, developing countries.[208] As a result many patients in developing countries may be grateful to receive any care at all, even if it is substandard.

3.3.4 Inadequate Health Care Systems and Large Informal Sectors

Developing countries often have immature, underdeveloped health care systems. Their public insurance schemes are often non-existent, or weak and underfunded, leading to significant out-of-pocket spending. In addition to this, a crucial distinction between developed and developing countries is that a large proportion of health spending in

207. Cortez, "Recalibrating the legal risks of cross-border health care," 40.

208. See World Health Organization, *Global Health Workforce Alliance, List of 57 Countries Facing Human Resources for Health Crisis, available at* http://www.who.int/workforcealliance countries/57crisiscountries.pdf (last visited October, 2015)

developing countries goes to providers in the informal economy.[209] There is an abundance of "rural medical practitioners, village doctors, quacks, and other names" who are not visible to regulators.[210]

3.3.5 Regulatory Deficits

Developing countries largely lack the regulatory capacity to set and enforce standards on health care providers. Developed countries, in contrast, can rely on overlapping layers of laws and regulations to encourage physicians, hospitals, and other providers to meet at least some minimum standards. In developing countries the overall framework for regulating their health sectors is weak, and Medical Councils as well as Departments of Health are poorly equipped.[211] As a result, medical professionals can escape meaningful regulation in these jurisdictions. Aside from regulating medical professionals, developing countries often lack effective hospital regulation and consumer protection regimes.[212]

3.3.6 Insignificant Private Insurance Markets

An important, though neglected, factor in developing countries is the lack of a robust private health insurance market. Private insurance can act as a channel for regulation. In developed countries like the United States, both public and private insurers often

209. See Anne Mills, "What Can Be Done About the Private Health Sector in Low-Income Countries?", *Bulletin of World Health Organization* 80:(2002) 325.

210. Gerald Bloom, "Regulating Health Care Markets in China and India",*Health Affairs* 27:(2008), 952, 954.

211. Cortez, "Medical Malpractice Model for Developing Countries, A", 224.

212. Mills, "What Can Be Done About the Private Health Sector in Low-Income Countries?" 327.

use their contracts with health care providers to pursue regulatory objectives such as patient safety and quality outcomes.[213]

3.3.7 Weak Civil Societies and Media

In developed countries, when regulatory markets do not come to the rescuer, the public might fall back on civil society and civil institutions for support.[214] Unfortunately, many developing countries lack strong civil societies to account for their regulatory deficits.[215] In Pakistan, however, the media is playing a crucial role in uncovering and raising public awareness of medical. Today, the media is also informing the public about the decisions of the newly set up Consumer Courts.

The above distinctions can affect "the capacity of the public sector to regulate, monitor, and negotiate with the private sector."[216] The study of the available models must, therefore, take into account these important factors.

3.4 Difficulties in Proving Malpractice Claims in the Developing World

The importance of redressing malpractice in developing countries cannot be brushed away, but it is equally difficult to effectively address a malpractice claim. Patients in developing countries frequently face four types of obstacles.[217]

- **Non-availability of Experts for Patients:** Patients often struggle to secure their own medical experts in adversarial litigation. Expertise may be

213. Cortez, "Medical Malpractice Model for Developing Countries, A," 226.
214. Jennifer Prah Ruger, "Global Health Governance and the World Bank," *Lancet* 370: (2007), 1471, 1473.
215. Ibid.
216. Cortez, "Medical Malpractice Model for Developing Countries, A," 226.
217. Cortez, "Recalibrating the legal risks of cross-border health care," 26.

scarce or unaffordable. Physicians may be unwilling to testify against other physicians known as the "conspiracy of silence."[218] In jurisdictions that require plaintiffs to prove negligence, this burden can be insurmountable without an expert who is willing to testify that the defendant breached the standard of care.[219]

- **Lack of Access to Medical Records:** Medical malpractice claims are difficult to prove in developing countries that do not grant patients access to their medical records.[220]
- **The Body of Law is Underdeveloped:** An obstacle for plaintiffs in developing countries is navigating an underdeveloped body of law. Legal experts in such countries lament that the law governing personal injuries in general, and medical malpractice in particular, is thin and antiquated.[221]
- **Lack of Access to Justice:** In developing countries, patientsfacing with access to justice. These jurisdictions frequently struggle with hugenumber of case backlogs, weak judicial institutions, inadequate legal infrastructure, corruption, and other problems endemic to the developing world.[222] Pakistan suffers from most of these problems. The problems exist in the urban as well as rural areas, but the plight of patients in some of the rural areas is absolutely intolerable.

We may now turn to the two models that are practiced today in developing countries.

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218. Ibid.
219. Cortez, "Medical Malpractice Model for Developing Countries, A," 227.
220. Ibid., 228.
221. Ibid. For the deficiencies in the law in general, see generally wardayasintort.
222. Ibid.

3.5 The Indian Model of Medical Negligence

Patients injured by medical malpractice in India can seek redress in one of two venues. They can sue in a consumer forum or they can sue in civil court. Suing in a civil court is not much of an option. Plaintiffs can sue for malpractice in India's civil courts under the Fatal Accidents Act, which compensates the families of those killed by an "actionable wrong," defined as death caused by a "wrongful act, neglect, or default."[223]The *Bolam* line of cases has made it very difficult for plaintiffs to prove medical negligence in Indian courts. Civil litigation in India is also known for its interminable delays. Plaintiffs may wait ten, twenty, or even twenty-five years for cases to conclude.[224] The delays deter many would-be plaintiffs. Experts have documented other reasons why India's civil courts are inhospitable to medical malpractice claims, and in aggregate, these obstacles make it difficult for plaintiffs to recover in civil courts.[225]

India now follows a new model for redressing medical malpractice. The procedure begins with the filing of a complaint in its consumer forums, also known as Consumer Disputes Redressal Agencies (CDRAs).[226] The details of this model have been dealt with in great detail in the previous chapters. Here we will merely undertake a brief assessment. It is also this model that Pakistan has followed. As recorded earlier, India originally created its consumer forums as an alternative to civil courts in general, not as a venue for resolving medical malpractice claims. India's 1986 Consumer Protection Act implemented the United Nation's 1985 Consumer Protection

223. The Fatal Accidents Act Section 1A, No. 13 of 1855, INDIA CODE (1993), available at http://indiacode.nic.in.

224. Cortez, "Recalibrating the legal risks of cross-border health care," 57.

225. Cortez, "Medical Malpractice Model for Developing Countries, A," 231.

226. Consumer Protection Act, No. 68, Acts of Parliament, 1986.

Resolution, which called for signatories to strengthen their consumer protection laws and enact "measures enabling consumers to obtain redress."[227] The Resolution was targeted at developing countries like India. A major goal of both the Resolution and the Act was to create a more accessible, realistic alternative for adjudicating consumer grievances, like complaints for receiving defective goods or services. No one expected the consumer forums to become the main avenue for adjudicating medical malpractice disputes.[228]

Medical malpractice plaintiffs typically file complaints for "deficient" medical services, defined as "any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance."[229] Legal scholars in India interpret this to require simple negligence, though it seems redundant with section 14 of the Act, "which awards compensation for negligence including compensatory damages, punitive damages (where appropriate), and costs, but they generally do not award noneconomic damages like pains and suffering."[230]

The Consumer Courts model followed in India compares very favourably to civil courts, even though it is not the quick six-month adjudication that the Act contemplates. "India's use of consumer forums certainly has been an antidote to its notoriously inefficient civil courts, but the forums are not ideal venues for resolving medical malpractice claims."[231] Plaintiffs have to overcome two significant obstacles. The first is finding a medical professional ready to affirm that another physician was wrong doer. This has already been discussed above. This does not mean that there is a

227. Cortez, "Medical Malpractice Model for Developing Countries, A," 231.
228. Ibid.
229. Consumer Protection Act, No. 68, Acts of Parliament, 1986, Section 2(c)(iii)(g).
230. Cortez, "Medical Malpractice Model for Developing Countries, A," 231.
231. Ibid.

shortage of experts; rather it is the "conspiracy of silence," referred to above as an obstacle for many developing countries. For that reason, some in India have proposed other solutions, such as using independent advisory panels on medical negligence cases, using special panels staffed with medical experts to hear all malpractice cases once a month, or requiring each panel in these cases to have at least one medical expert on staff.[232] These proposals, however, have not been given a practical shape for the time being. Obtaining medical records is the second obstacle for malpractice plaintiffs in India's consumer forums.[233]Patients are not allowed generally to have access to the basic information about their course of treatment or the medications they receive and Physicians and hospitals in India often refuse to hand over documents to them.[234] A 1996 opinion by the Bombay High Court held that "medical providers must give records to patients or their families," but this opinion has not made much difference.[235] In 2002, the Indian Medical Council finally created regulations that require practitioners to keep records for at least three years and disclose them to patients too, but there is no evidence that the Council enforces them.[236] The National Commission has now held that hospitals are not required to maintain or disclose medical records under the Consumer Protection Act.[237] For these reasons, plaintiffs hardly ever succeed in filing complaints against medical practitioners under the Consumer Protection Act. Various sources report that plaintiffs lose 70- 90% of malpractice cases in the consumer forums.[238]

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232. Ibid.
233. [Ibid.
234. Ibid., 232.
235. Raghunath G. Raheja v. Maharashtra Med. Council, 1996 A.I.R. 198 (Bom.) 203.
236. Cortez, "Medical Malpractice Model for Developing Countries, A," 232.
237. Poona Med. Found. v. Maruttrao Tikare, (1995) 1 C.P.R. 661.
238. Cortez, "Medical Malpractice Model for Developing Countries, A," 232.

All the above obstacles show that even the Consumer model is beset with great difficulties. Experts in Pakistan must make note of these obstacles and try to find remedies so that the model adopted succeeds.

3.6 The Medical Negligence Model of Mexico

Mexico is a civil code jurisdiction, which means that Mexican courts do not use familiar common law doctrines like stare decisis, and judges are not really bound by any common law precedents.[239] Personal injury cases in Mexico are governed by the Federal Civil Code, or one of the thirty-one state codes that largely track it. These codes remedy personal injuries and deaths through "extra-contractual liability" that arises from illegal acts based on duties and obligations owed to one another.[240] Mexican law on personal injury claims similar to tort law is not fully developed. And Mexican courts cannot fill the void in the same way that common law courts can. Thus, Mexican law governing personal injuries remains severely underdeveloped and outdated.[241] For all these reasons and others not mentioned, patients rarely bring malpractice cases in Mexico's civil courts.

But as in India, an alternative emerged. In 1996, then President Ernesto Zedillo declared that a new national arbitration agency would be formed within Mexico's Ministry of Health.[242] Thus, the National Commission for Medical Arbitration

239. Jorge A. Vargas, "An Introductory Lesson to Mexican Law: From Constitutions and Codes to Legal Culture and NAFTA," *San Diego Law Review* 41:(2004), 1337, 1353.

240. Cortez, "Medical Malpractice Model for Developing Countries, A," 236.

241. Ibid.

242. Carlos Tena-Tamayo & Julio Sotelo, "Mal-practice in Mexico: Arbitration Not Litigation," *British Medical Journal* 331: (2005), 448–49.

(Commission Nacional de Arbitraje Médico, or "Conamed") was born.[243] The system is described in the following words by Cortez, along with his recommendations:

> Like India's consumer forums, Conamed was designed as a more accessible, efficient, and less costly alternative to civil courts.158 But unlike India's consumer forums, Conamed was designed specifically to handle disputes over medical care a feature that developing countries might emulate. Conamed's primary charge is to mediate disputes between patients and providers, saving the parties from litigating in civil, criminal, or administrative venues. Conamed can resolve cases at any one of these three stages. Roughly 73% of cases are resolved at the first stage, within two days of a conflict being submitted to Conamed. The first stage involves an immediate, somewhat informal intervention that opens the lines of communication between the patient and provider, sometimes involving one of Conamed's specialized consultants. This relatively quick and informal initial intervention might be particularly attractive to both patients and providers in developing countries that have a low tolerance—and few resources—for adversarial litigation.[244]

The parties usually resolve their dispute in the first step described above, but if they do not resolve their dispute during this initial intervention, a complaint is filed with Conamed, and the case proceeds to conciliation.[245] Conamed's experts screen complaints before formally accepting them for conciliation, separating medical malpractice cases from disputes over other matters, like a physician refusing to treat a

243. See http://www.conamed.gob.mx/index.php.(accessed November, 2015).
244. Cortez, "Medical Malpractice Model for Developing Countries, A," 238.
245. Ibid.

patient.[246] The second conciliatory phase introduces a medical review by both Conamed's experts and the treating physician. The parties can then sign a conciliatory agreement, or opt out of the Conamed process and file a lawsuit, or proceed to the last stage, arbitration.[247] To arbitrate, the parties must sign an agreement that precludes them from taking the case to court. The arbitrators are independ-ent physicians or attorneys trained to handle these cases. Conamed supports the arbitrators by peer-selecting expert consultants based on the medical issues in each case.[248] Conamed thus enjoys credibility both with the judicial and medical communities in Mexico. If arbitrators conclude that the physician committed malpractice typically through "negligence or inexperience" it can award compensation, including damages, medical expenses, or cancelling the patient's debt to the provider.[249]

This in brief is the model implemented in Mexico as compared to the model implemented in India. The model is preferred by some over the Indian model, which has been adopted by Pakistan.

3.7 The Consumer Law Model and Future Projections

Those injured can, like India, see redress in one of two venues in Pakistan. They can sue in a consumer forum or they can sue in civil court. Suing in a civil court is only a theoretical option as people have stopped having recourse to them under the law of torts.[250] Again, like India, plaintiffs can sue for malpractice in the civil courts under the Fatal Accidents Act, which compensates the families of those killed by an

246. Ibid.

247. Ibid. Between 2001 and 2003, roughly 27% of cases proceeded to conciliation, over half of which were resolved at this second stage, typically within three to six months.

248. Ibid.

249. Ibid.

250. Details have been recorded by Professor Warda Yasin in an article that describes the state of the law of torts in Pakistan. See warda yasin tort.

"actionable wrong," defined as death caused by a "wrongful act, neglect, or default."[251] The survivors can sue, again as in India, in civil court for common law negligence. The law was inherited as the common law system from Britain, as in India, and it uses a formula that requires tort plaintiffs to establish duty, breach, causation, and damages. The situation is exactly the same as in India, and we need not repeat the details here. One difference is about the Fatal Accidents Act of 1855.

A Press Release dated February 02, 2006 appearing on the website of the Law and Justice Commission of Pakistan, contained a notice about the meeting of the Commission to be held on February 4th, 2006. The agenda had the following as one of the items to be discussed: "Repeal of the Fatal Accidents Act 1855."[252] A news report appearing later had the following to say: "The commission also examined the Fatal Accidents Act 1855, providing right to seek damages to the heir of the victim. The law was enacted when there was no law of Diyat. The offence of qatl-i-khata committed by fatal accident is liable to Diyat under the Pakistan Penal Code which is a form of compensation to the heirs of the victim, therefore, the provisions of Fatal Accident Act 1855 came in conflict with the Pakistan Penal Code. The commission, therefore, recommended the repeal of Fatal Accident Act 1855."[253]

As stated above, Cortez, the author quoted profusely above, prefers the system of arbitration adopted in Mexico. He suggests that developing countries should adopt the solution found in the Mexico model. The main difference between the two models is that the Indian model based on the consumer law is a much wider system in which the

251. The Fatal Accidents Act available at http://www.sja.gos.pk/Statutes/Civil\%20Major\%20Laws/The\%20FATAL\%20ACCIDENTS\%20ACT\%201855..html.

252. http://www.ljcp.gov.pk/media\%20release/Press\%20Release2-2-06.htm.

253. http://www.dawn.com/news/177347/commission-for-instant-probe-by-judges-death-suicide-in-jails.

law dealing with medical negligence was imported later by the courts. As compared to this, the model followed in Mexico is dedicated solely to medical malpractice. The consumer courts in India, and hence in Pakistan, work more or less like courts, although in India they are not called courts. The system in Mexico is arbitration and reconciliation based system. Finally, the panels employed by the Mexico system are using experts and they do not have to run around for experts. The lack of experts for testifying on behalf of the plaintiff is the biggest cause of the failure of the consumer law system, just like the civil courts. Cortez has the following to say in conclusion and in favour of the Mexican model:

> Developing countries differ from ours in important ways, and these differences suggest that it is particularly important for patients to have realistic avenues to redress their medical grievances. India and Mexico provide two different models, both of which depart from traditional civil litigation. Mexico's model is a superior alterna-tive to India's because Mexico eliminates the requirement that pa-tients carry the burden of proof by securing medical records and ex-pert testimony from reluctant parties. Mexico's system is also less adversarial, which may better accommodate the fiscal and cultural realities in developing countries.[254]

The consumer model is implemented in Pakistan to the extent of the province of Punjab. In the other provinces, and in the Federal area, it is suggested that the Mexican model may be considered and implemented with the help of civil society,

254. Cortez, "Medical Malpractice Model for Developing Countries, A," 238.

The introduction was then followed by the study of medical negligence within the consumer law in great detail. The history of the introduction of consumer law in India was explained.

The legislation in Pakistan dealing with consumer law was assessed. As the Province of Punjab has taken the lead in developing the whole system including the detailed infrastructure laid out by Punjab Consumer Protection Act, 2005, and Rules 2009. The meaning of free service and service for a consideration was then analysed and it was explained how the law views the patient as a consumer. As liability for medical negligence arising out of defective and faulty services under the consumer law, this concept was elaborated in great detail. The Consumer Protection Council is playing a very active role and is maintaining a highly informative website that gives complete information about all cases including medical negligence cases decided by the consumer courts. The simplified procedure for filing complaints and effectuating cases was then explained along with the details about the type of cases settled. The types of damages awarded were analysed. Finally, it was indicated that the major problem for the new system can arise from the non-availability of medical experts who can testify for the plaintiff. The availability of patient records to the plaintiff was also discussed. The system has made a good start and a number of cases have been settled with a few very significant cases with huge damages awarded.

In the final chapter, a study was conducted to assess the other models that were adopted in the developing world. After assessing the factors that beset the developing countries—like poverty, excess of infectious diseases, lack of medical infrastructure, paucity of trained professionals and the like—two major models dealing with medical malpractice were taken up and described. In the end, it was concluded that the model

adopted by Mexico was more suitable for developing countries as compared to the consumer law based model adopted by India. In addition, it was concluded that one of the major reasons for the failure of the consumer law based system was the lack of medical experts available for the purpose of testifying for the plaintiff as one doctor would not go against another fellow doctor. Another reason was the non-availability of medical records to the patient who had filed a claim against a doctor or a hospital. The situation would be much better if these areas were subjected to reform and improvement.

4.2 Recommendations

The recommendations of this study are few and simple. The first set of recommendations is mainly for the Province of Punjab. These are as follows:

- An effort should be made to provide independent and qualified medical experts to the plaintiff, who sues a doctor or a hospital. The system in India and other jurisdictions may be studied for reforms in this area.
- Legislation should be made to ensure that accurate medical records are made available to a suing plaintiff on time.
- The consumer law focuses on monetary damages alone limiting them to the extent of physical damage caused. A study should be undertaken to examine whether punitive and other damages may also be permitted for cases of medical negligence.

The Federal Capital and the other three provinces do not yet have a developed medical negligence component for their consumer laws. Here it may be mentioned that the Province of Sindh lags behind the other areas. The governments of these areas may study the feasibility of following the Mexican model of medical malpractice instead of blindly following India and its consumer law solution for medical negligence.

Finally, it is suggested that different NGOs and associations working in the area of healthcare should adopt the mission of the worldwide "Patient Safety Movement", which is working to save lives and helping to save preventable patient deaths. Seeking support from this movement is likely to be highly beneficial for the health care environment in the country. The movement brings together IT infrastructure and

medical technologies and with relevant information, intelligent and predictive algorithms, and decision support that facilitates process of care improvements. It attempts to keep physicians and patients informed of dangerous trends, and generally undertake campaigns through which lives could be saved, and costs could be dramatically reduced. The website of the movement says that the following tasks are performed:[255]

1. To unify the healthcare ecosystem;
2. To identify the challenges that are killing patients to create actionable solutions;
3. To ask hospitals to implement Actionable Patient Safety Solutions;
4. To promote transparency;
5. To ask medical technology companies to share the data their devices generate in order to create a Patient Data Super Highway to help identify at-risk patients;
6. To correct misaligned incentives;
7. To promote love and patient dignity; and
8. To ultimately get to ZERO preventable deaths by 2020!

The Patient Safety Movement is taking on this challenge and is galvanizing the entire healthcare ecosystem. In general, it will be a good idea if civil society in Pakistan contributes to this movement.

255. http://patientsafetymovement.org/.

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