REPORT

A study on

Medical Negligence

and

Fraudulent Practice in Private Clinics: Legal Status and Bangladesh Perspective

Consultant:
Tapos Bandhu Das, Advocate
Judges' Court, Sylhet

Duration: March-April 2013

Prepared for:
Ain o Salish Kendra (ASK)
7/17 Block B, Lalmatia, Dhaka-1207

TABLE OF CONTENTS

Acknowledgements

This study has been conducted as a part of legal research for law and policy reform as per requirements of Legal Advocacy and Policy Reform Unit of Ain o Salish Kendra (ASK). As a human rights organization, ASK has been engaged protecting and promoting human right including right to health and health care. Medical Negligence is one of the major issues that cause serious infringement of right to health. ASK has been addressing this issue for more than a decade. The Legal Advocacy and Policy Reform Unit of ASK is responsible for legal intervention and advocacy for law and policy reform. This study has been conducted to facilitate policy interventions and future legal actions of Advocacy Unit in respect of medical negligence.

I am grateful to all the members of Legal Advocacy and Policy Reform Unit of ASK who rendered a generous support by providing the case materials and PIL documents of ASK. I would also like to express my gratitude to the Documentation Unit, Investigation Unit and Publication Unit of ASK who extended a great support by providing the previous reports, statistics, investigation reports, publications on medical negligence. I owe a special thanks to Mr. Abu Obaidur Rahman, Advocate, Supreme Court of Bangladesh and Deputy Director of ASK for his kind guidance in preparing the report.

I am indebted to all the authors and researchers, whose work has been referred to in this report. I must express my gratitude to my teacher Dr. Ridwanul Hoque for his keen observation and academic guidance in preparing this report. I would also like to thank Mabruk Mohammed, a fresh graduate from University of Dhaka, who assisted me in data collection and research work. Finally, I would like convey my respect and gratitude to all the present and past members of ASK who had contribution in its previous researches and studies on medical negligence.

Executive Summary

Medical Negligence is an issue of serious human rights concern that directly affects right to life and right to health care. The term medical negligence generally refers to the negligent or rash act of medical professionals in violation of the duty of care they owe to their patient. In a broader sense of the term, or when medical negligence is referred to as an issue, it also includes other kinds of professional misconduct causing sufferings of the patients. Medical negligence, both in public and private health care sectors of Bangladesh, is a major human rights concern for which ASK has been engaged in advocacy for law and policy reform for more than a decade. This report is commissioned by the Legal Advocacy and Policy Reform Unit of ASK to ascertain the legal status of medical negligence and fraudulent practice in private clinics in the context of Bangladesh.

The overwhelming number of incidents of medical negligence mostly goes without any legal action, leading to a frustrating situation where public trust is completely lost on the medical service providers. As a human rights organisation, ASK has a strong mandate for protection and promotion of right to health and health care. The activities of ASK in this regard ranges from legal aid to advocacy for law and policy reform. ASK provides legal aid to the victims of medical negligence. Although the legal remedies available under the existing laws are limited or difficult to access, such efforts give a clear idea about the shortcoming of the existing law and the underlying difficulties in the judicial system. Besides, legal aid also serves to encourage the helpless and/or poor victims to assert their legal right to have proper treatment. In addition to legal aid ASK also conducts fact finding investigation on different allegations of medical negligence. ASK's activities also include publication for raising awareness about medical negligence and its legal remedies.

In order to ascertain the legal status of medical negligence the existing legal regime has been studied in this report. The Constitution of Bangladesh recognizes right to health care and guarantees right to life. Bangladesh is also a party to a number of international instruments, under which the Government has an obligation to protect and promote right to health. The National Health Policy of 2011 has been analyzed in this report. It appears from the policy statements of the Government as enumerated in the Health Policy and other policies discussed in this report that although right to health has been given due importance in those policies, the issue of accountability in health care sector has not been dealt with adequately. The different laws relating to medical services have been analyzed in this report. The laws include the Vaccination Act, 1880; the Drugs Act, 1940; the Eye Surgery (Restriction) Ordinance, 1960; the Pharmacy Ordinance, 1976; the Drug (Control) Ordinance, 1982; the Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982; the Bangladesh Unani and Ayurvedic Practitioners Ordinance, 1983; the Transplant of Organ in Human Body Act, 1999; the Safe Blood Transfusion Act, 2002; the Consumer Rights Protection Ordinance, 2008; the Bangladesh Medical and Dental Council Act, 2010. In addition to these laws, the relevant provisions of the Penal Code, 1860 have also been discussed that can be applied in different instances of medical negligence, malpractice and fraudulent activities of the private clinics and others. The provisions of the Code of Medical Ethics have also been discussed to analyze the standard of care and responsibilities of the medical professionals as adopted by the BMDC. There are certain gaps and missing provisions in the laws which have been separately discussed in this report. Nevertheless, it is worth mentioning that even though there are many provisions in the existing laws that can be applied to control, prevent or redress the negligent activities, those provisions are not generally observed to be applied due to irresponsibility or lethargy of the concerned monitoring authorities.

The available redresses or punitive actions under the existing laws have been discussed in this report. The remedies or actions include departmental proceeding, criminal action, civil suit for compensation, remedy under the Consumer Rights Protection Ordinance and judicial review. The departmental proceeding in cases of medical negligence seems very rare in Bangladesh. The BMDC, as a regulatory body of physicians and dentists and medical assistants, is legally empowered to initiate such proceedings. But unfortunately, such proceedings have not been observed to be initiated by the BMDC to bring in discipline in the profession. Criminal action can be taken in appropriate cases of negligence. Civil suit for compensation can be a common option in all cases of medical negligence, which is also rarely

resorted to by the victims. There is also a scope for claiming compensation under the Consumer Rights Protection Ordinance, 2008. Judicial review can be a strong weapon to address the monitoring aspects and accountability issues regarding medical negligence.

This report contains a comparative analysis of different national jurisdictions in addressing medical negligence. The comparative assessment aims at two different aspects; one is legislative arrangement and the other is judicial intervention. The experience of India, Nepal and Malaysia has been discussed in analyzing the legislative arrangement and legal practices to address medical negligence. For judicial intervention regarding right to health care, two case studies from India and South Africa has been presented and discussed in this report. The report finally offers a set of recommendations for legal and policy level intervention and improvement of existing practice. An accountable system of medical administration coupled with effective legal arrangements, under the surveillance of a vigilant civil society can establish a safe and sensible health care system in Bangladesh.

Abbreviations

ASK	Ain o Salish Kendra
BMA	Bangladesh Medical Association
BMDC	Bangladesh Medical and Dental Council
CEDAW	Convention on Elimination of All forms of Discrimination against Women
CPC	Code of Civil Procedure, 1908
CRC	Child Rights Convention
CrPC	Code of Criminal Procedure, 1898
ICESCR	International Covenant on Economic, Social and Cultural Rights
NHP	National Health Policy
NWDP	National Women Development Policy
UDHR	Universal Declaration of Human Rights
UN	United Nations
WHO	World Health Organization

List of Instruments and Laws

The Constitution of Bangladesh, 1972

The Penal Code, 1860

The Vaccination Act, 1880

The Code of Criminal Procedure, 1898

The Code of Civil Procedure, 1908

The Drugs Act, 1940

The Eye Surgery (Restriction) Ordinance, 1960

The Pharmacy Ordinance, 1976

The Drug (Control) Ordinance, 1982

The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982

The Bangladesh Unani and Ayurvedic Practitioners Ordinance, 1983

The Transplant of Organ in Human Body Act, 1999

The Safe Blood Transfusion Act, 2002

The Consumer Rights Protection Ordinance, 2008

The Bangladesh Medical and Dental Council Act, 2010

The National Child Policy, 1994

The National Health Policy, 2011

The National Women Development Policy, 2011

The Code of Medical Ethics, adopted by the Bangladesh Medical and Dental Council

Part I

Introduction

Medical negligence mainly concerns negligent or rash act of medical professionals causing any injury to the patient. Medical negligence is a kind of professional misconduct on the part of a medical practitioner. In a strict sense the term, medical negligence, may not include professional misconduct or malpractice of other kinds such as fraudulent misrepresentation regarding eligibility or qualification, prescribing unnecessary drugs or tests for undue profit, taking undue advantage of the patient's situation etc. But, while addressing medical negligence from a human rights perspective, the whole range of medical malpractice and misconduct including the professional negligence of medical professionals, has to be taken into consideration. Because, all these vices have one thing common in consequence; they cause serious violation of right to health and access to medical care. More importantly, these issues have a nexus at their origin and coexistence. Therefore, while dealing with medical negligence and right to health care, it is also essential to consider these aspects of medical services in order to make a comprehensive assessment. Fraudulent practice of the private clinics is also a matter of serious concern in Bangladesh. With due attention to the varied pattern of such fraudulent practices, it can be suggested that such activities should also come under the broader head of medical malpractice, since in addition to the criminal liability attached to these wrongs, they also cause grave violation of right to health care and access to appropriate treatment. This study aims at the broader aspect of right to health care and medical services with specific emphasis on the legal issues related to medical negligence and fraudulent practice of private clinics.

1.1 Background

This study is a legal research for law and policy reform under the legal advocacy and policy reform initiatives of Ain o Salish Kendra (ASK). Legal Advocacy and Policy Reform Unit of ASK is mainly responsible to carry on advocacy initiatives towards law and policy reform. Medical negligence is one of the issues that the Unit is consistently pursuing for more than a decade with a view to ensure people's right to health care and access to medical services. The interventions of the Legal Advocacy Unit mainly focus on accountability of the health care providers and their regulatory bodies. Although, on many occasions and to a certain extent the interventions of ASK resulted in a positive outcome, the overall progress of human rights situation

in health care sector is insignificant. Therefore, at this point, ASK feels it necessary to review the legal regime relating to medical and health care services, and have a recast of the limitations and challenges summarizing its experiences in this field. Hence, ASK decided to conduct this study titled as 'Medical Negligence and Fraudulent Practice of Private Clinics: Legal Status and Bangladesh Perspective'.

1.2 Methodology

This study is mainly based on analysis of the existing laws and policies relating to medical services and medical malpractice. It relies on a number of previous reports, publications, laws and policies. The study also attempts a comparative analysis of other countries' experiences in legislations and litigations involving medical negligence, such as India, Nepal, Malaysia and South Africa.

This study makes a comprehensive assessment of the legal regime of Bangladesh concerning medical negligence. Starting from constitutional safeguards in favour of right to health care, it analyzes the different aspects of policy statements of the Government that have been reflected in the National Health Policy of 2011 and other two policies on development of women and children. The study examines a series of statutes which are relevant to medical services. The statutes reviewed in this study include:

- The Vaccination Act, 1880
- The Drugs Act, 1940
- The Eye Surgery (Restriction) Ordinance, 1960
- The Pharmacy Ordinance, 1976
- The Drug (Control) Ordinance, 1982
- The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982
- The Bangladesh Unani and Ayurvedic Practitioners Ordinance, 1983
- The Transplant of Organ in Human Body Act, 1999
- The Safe Blood Transfusion Act, 2002
- The Consumer Rights Protection Ordinance, 2008
- The Bangladesh Medical and Dental Council Act, 2010

On identifying the gaps in the legal regime, this report cites some statutory/legal arrangement of some other countries in providing remedy against medical negligence. The study also attempts to identify the possible remedies available under the existing legal regime. Since, PIL is an effective

tool for legal and policy intervention, the study also deals with the scope of PIL to ensure accountability in medical services. In contrast of the domestic experience with medical negligence PILs in Bangladesh, two case studies from India and South Africa has been cited and discussed in this study. Finally, based on the assessment and discussions, the limitations and challenges have been identified and recommendations have been made for legal advocacy and policy intervention to ensure accountability in the field of medical and health care services.

1.3 Ambit and Aims of the Study and Structure of the Report

The present study aims at ascertaining the legal status of medical negligence and fraudulent practice of private clinics on review of existing laws and policies of Bangladesh. It should be noted that the first part of the title of the study 'Medical Negligence' refers to the overall situation of medical negligence and malpractices existing in both public and private sector, while the latter part 'Fraudulent Practice in Private Clinics' refers to the fraudulent practice of private clinics to signify a special emphasis on that particular phenomenon. This study also aims to identify the gaps and inconsistencies in the existing laws and policies to ensure accountability of health care service providers and to protect the right to health care of the citizens. The study finally attempts to make certain recommendations as to law and policy reform concerning medical negligence and malpractice. The ambit of the study is limited to the assessment of the relevant laws and policies of Bangladesh. It also relies on a number of previous works and publications, including some of ASK's own studies and publications.

This report contains eight parts. Each part has a number of segments with separate headings. Part I deals with the context of the study and preliminary discussions on medical negligence. Part II describes ASK's involvement with the issue. Part III examines the legal regime as well as attempts to identify the gaps. Part IV elucidates the possible remedies against medical negligence under the existing laws, while the next Part offers a comparative analysis of the experience of other countries. Explicating different aspects of two relevant PILs filed by ASK, Part VI tends to measure the scope of PIL in seeking accountability for medical malpractices, and also compares the experience of India and South Africa with two case studies. Part VII provides recommendations for law and policy reform. It also includes some recommendations regarding improvement of existing practices. Part VIII concludes the report.

1.4 Medical Negligence: Preliminary Discussion

Medical negligence generally refers to an act or omission by a physician, dentist, nurse, medical assistant, pharmacist or any other medical service provider in breach of requisite duty of care to the patient. There are certain elements which must be proved in order to establish an accusation of medical negligence; such as existence of a doctor-patient relationship, an act or omission by the doctor violating the requisite duty of care, and actual damage or injury caused to patient as a result of that act or omission. The relationship of the alleged act or omission to the actual loss or damage must be established.

In most of the countries, medical negligence is generally viewed as an actionable civil wrong, the remedy for which is commonly monetary compensation. In common law jurisprudence, it comes within the purview of the law of torts. Some countries deal the matter generally under the law of torts, such as Malaysia (see 5.1.3); while some countries provide for separate legislation with specific judicial forum to redress such wrong e.g. in India medical negligence cases are adjudicated under the Consumer Protection Act (see 5.1.1.2). Medical negligence or malpractice, however, may sometimes give rise to criminal offence as well. Such offences are generally dealt with the penal laws of the country.

Ascertaining the damage caused to the patient or victim is very important in litigations involving medical negligence. The damage must be actual and not too remote. The damage can be measured in terms of (i) additional financial expenses for treatment of the complication resulting as a consequence of negligence, (ii) loss due to absence from work, (iii) decreased life expectancy, (iv) loss of organ or limb, (v) death of the patient who could be a wage earner for the family, (vi) loss of consortium etc. The defences that can be set out by the accused may be (a) actual denial that the injury is negligence, (b) contributory negligence on the part of the patient, (c) delegation of duties to a qualified assistant or partner, (d) inherent risk, (e) emergency situation, (f) known complication, (g) unexpected results, (h) difference of opinion[1].

[1] This principle is known as Bolam's Test. In *Bolam Vs. Frirern Hospital Management Committee* (1957), 1 WLR 582, it was held that if there are two accepted schools of thoughts for any treatment, the doctor may apply any one of them. If any complications arise due to the particular method which is recognized and approved by an accepted school of thought, the doctor cannot be held responsible only on the ground that why he did not apply the other method.

1.5 Medical Negligence in Bangladesh and Its Impact on Right to Health Care

Medical negligence includes a wide range of negligent conducts i.e. acts or omissions. If medical negligence is construed in a broader sense to include different types of medical malpractice and misconduct, then it becomes all the more important to categorically identify the nature and trends of such negligence or malpractice prevailing in a given jurisdiction. In order to determine the areas of intervention for law and policy reform, the predominant trends of medical negligence must be taken into account. However, it is not meant to say that those types of negligence or malpractice which are less recurrent need not be taken seriously. But to address an overwhelmingly[2] malfunctioning medical service system, prioritization is essential. Besides, an assessment of the recurring trends will definitely render an insight to the root of the problem. Most of the terribly shocking incidents of medical negligence show some common traits, an analysis of which can give an idea about the missing chords.

In an interview for ASK, Professor Rasheed-e-Mahbub, the former President of Bangladesh Medical Association (BMA) resorted to the much repeated excuse of imbalanced doctor-patient ratio and lack of resources and equipments (ASK, 2008: 71). These limitations, however, cannot be denied. According to the WHO, per capita expense on health sector should be 34 US Dollar, whereas it is only 5 US Dollar in Bangladesh. The standard ration for doctor to nurse is 1:3, whereas in Bangladesh it is 1:0.48 (NHP, 2011:7). But, both these limitations are such an obvious reality for Bangladesh which cannot be changed overnight. Nevertheless, there are many instances in which such constraints had nothing to do with the alleged act or omission.

As it has been thoroughly investigated, documented and published by ASK in its investigation reports, quarterly bulletins and other publications, a discussion of particular instances of medical negligence would be a repetition for this study. Nevertheless, it appears from the incidents investigated and reported by ASK at different times that almost all the severe incidents of negligence hints to one common lacuna i.e. lack of accountability coupled with an

[2] Although there is no methodical study till date that categorically reveals the statistics of medical negligence in Bangladesh; this information is enough to establish the general public contention regarding health care service. Based on the reported incidents of medical negligence published in different national dailies, ASK's publication *Chikitshay Obohela* (2008: 150-185) provides a list of 504 incidents of severe medical negligence leading to death or loss of organ etc. over the period June 1995- September 2008. This figure, obviously could be much higher if all the incidents had been counted, and if unreported incidents had also been taken into account.

ineffective monitoring system. When negligence of gross types, such as removing the functional kidney instead of the failed one (Case study: Rubel; ASK, 2008: 26) or surgery on the right eye instead of left one (Case study: Baitus Sharaf Complex; ASK, 2008: 41) remain without any action from any of the monitoring authorities, the question of other types of negligence involving intricate questions of medical science does not arise at all. Therefore, the overall situation of accountability in medical services is very frustrating.

The most serious impact of such uncountable incidents of medical negligence and their going unpunished has strongly established a culture of impunity in the health care sector, both public and private, which is a serious threat to right to health care. The poor people are more vulnerable in such a context. Their very access to health care services is in a sense denied by this culture of impunity. It is very rare even for the well off victims of medical negligence to seek legal redress. Even if redress is sought for, the result is predictably negative. All summed up, the overall impact of medical negligence is a strong sense of public distrust on the health care system, mixed with fear and helplessness.

Part II

Medical Negligence and Fraudulent Practices in Private Clinics: ASK's Involvement

ASK has been involved in advocacy for right to health care for more than a decade. Addressing the issue of medical negligence is a core area of ASK's intervention. ASK's activities and involvement with the issue ranges from investigation to policy intervention. ASK's main actions regarding medical negligence include:

1. Legal Aid
2. Investigation
3. Addressing Incidents of Medical Negligence and Fraudulent Practices
4. Publication
5. Policy Intervention: Advocacy for Law and Policy Reform
6. Public Interest Litigation (PIL)

ASK provides legal aid to the victims of medical negligence. Although the legal remedies available under the existing laws are limited or difficult to access, such efforts give a clear idea about the shortcoming of the existing law and the underlying difficulties in the judicial system. Besides, legal aid also serves to encourage the helpless and/or poor victims to assert their legal right to have proper treatment. In addition to legal aid ASK also conducts fact finding investigation on different allegations of medical negligence. These

investigations reveal the actual scenario of the health care services and the factors contributing to medical negligence. The investigation reports are also cited in the PILs of ASK, which form a credible basis of its statements before the Hon'ble Court. ASK also addresses particular incidents of medical negligence by sending urgent appeals to the concerned health authority to take appropriate actions regarding the reported allegations of negligence. Publication is another effective means employed by the ASK to raise awareness against medical negligence. The Publication Unit of ASK publishes different investigation reports, features and articles on medical negligence. In 2008 ASK published *Chikitshay Obohela,* a Bangla compilation of its previously published and new works on medical negligence. Advocacy for law and policy reform is another important area of ASK's work. ASK regularly interacts with the government machineries and policy makers to bring in positive changes in the laws in order to ensure accountability in medical services. It also moves to the Supreme Court with PILs on medical negligence. The Legal Advocacy and Policy Reform Unit of ASK is responsible for law and policy reform and to file PILs before the Hon'ble High Court Division of the Supreme Court.

Part III

Medical Services and Operation of Private Clinics in Contrast of Right to Health and Medical Care: A Review of the Existing Legal Regime in Bangladesh

Medical services include a wide range of activities; from diagnosis to medicine, surgery and other forms of treatment. In this part, the legal regime in Bangladesh relating to medical and health care services and operation of private clinics, laboratories etc. have been discussed and analyzed. This part starts with the assessment of constitutional safeguards; then it infers Bangladesh's obligation to ensure right to health care under the provisions of the international treaties. Upon a comprehensive evaluation of the policies and laws, this part then analyzes the gaps and inconsistencies of the existing laws and policies. Finally, it concludes with the proposal of the Law Commission emphasizing the need for a specific legislation afresh.

3.1 Constitutional Safeguards

The Constitution of Bangladesh recognizes right to health and medical care as fundamental necessity of every citizen. Article 15 of the Constitution sets it to be a fundamental principle of State Policy to "attain, through planned

economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens-

> (a) the provision of the basic necessities of life, including food, clothing, shelter, education and medical care;
>
> ...
>
> (d) the right to social security that is to say, to public assistance in cases of undeserved want arising from unemployment, illness or disablement, or suffered by widows or orphans or in old age, or in other such cases."

Article 18 of the Constitution further provides:

> "18. (1) The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties ..."

Thus, although the Constitution does not expressly recognize right to health and medical care as fundamental right, it is evident from the constitutional provisions as mentioned above, that the framers of the Constitution do intended for progressive realization of such rights. The constitutional sanction in favour of right to health and medical care can further be inferred from Article 32 of the Constitution that guarantees right to life as a fundamental right. It has been observed in a number of Public Interest Litigation (PIL) cases that the right to life has already been construed in a wider sense to include right to safe environment[3] and right to livelihood[4]. In a similar vein, the fundamental right to life can also be interpreted to include right to health and appropriate medical care.[5]

In addition, health and treatment are such basic needs of human life that they cannot be excluded from the essential preconditions of a secured human life and the State has some positive obligations to ensure those rights. The Preamble to the Constitution offers a strong support for this argument:

---

[3] *Dr. Mohiuddin Farooque Vs. Bangladesh and others*; 48 DLR, (1996) HCD 438

[4] *Ain o Salish Kendra Vs. Government of Bangladesh*; 19 BLD, (1999) HCD 489

[5] For a detailed discussion on how ESC rights recognized as fundamental principles and typically understood as unenforceable rights, made their way to judicial enforcement with the aid of progressive interpretation of "right to life" see Hoque, Dr. Ridwanul; *Taking Justice Seriously: Judicial Public Interest and Constitutional Activism in Bangladesh,* Contemporary South Asia 15 (4), December, (2006) 405

> "... it shall be a fundamental aim of the State to realise through the democratic process a socialist society, free from exploitation- a society in which the rule of law, fundamental human rights and freedom, equality and justice, political, economic and social, will be secured for all citizens; ..."

Therefore, it is apparent that the entire scheme of the Constitution, to a considerable extent, is in favour of right to health and medical care. However, while addressing medical negligence and fraudulent practices of private clinics, some other provisions of the Constitution are also relevant. Apart from State's responsibility to protect and promote right to health and medical care, there is another aspect of the issue i.e. the responsibility of individuals and institutions delivering health care and medical services vis-a-vis the rights of the citizens who are the receiving end of the services. As Article 21 of the Constitution provides:

> "21. (1) It is the duty of every citizen to observe the Constitution and the laws, to maintain discipline, to perform public duties and to protect public property.
>
> (2) Every person in the service of the Republic has a duty to strive at all times to serve the people."

Article 27 provides for equality before law and 28, for non-discrimination. Article 40 entitles a citizen, possessing such qualification, if any, as may be prescribed by law in relation to his profession, occupation, trade or business, to enter upon any lawful profession or occupation, and to conduct any lawful trade or business, subject to any restriction imposed by law. These constitutional guarantees are also relevant in dealing with medical negligence; because any measure adopted or scheme developed with a view to establish accountability and to provide for adequate remedy or redress of grievances relating to medical negligence should be in conformity with this 'delicate balance' of the constitution that can come into play between rights of the patients and occupational freedom and protection of the physicians and other medical professionals.

3.2 Obligations of Bangladesh as a State Party to the International Human Rights Treaties

Bangladesh is a party to the major international human rights treaties including Universal Declaration of Human Rights (UDHR), 1948; International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966; Convention on Elimination of All Forms of Discrimination against Women

(CEDAW), 1979; Convention on the Rights of the Child (CRC), 1989. Therefore, as a state party Bangladesh has obligation under these international instruments, both moral and legal, to fulfill its commitment to protect and promote health rights of the citizens, which obviously includes easy access to medical and health care facilities, right to have appropriate and adequate treatment and thus, inferring the right to have an effective remedy in case of violations of those rights.

Article 25 of the UDHR states:

> "(1) 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, 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 circumstances beyond his control.
>
> (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."

Article 3 of the Declaration provides for right to life, liberty and security of person, while Article 2 provides for principle of non-discrimination.

The ICESCR specifically emphasized on right to health and medical care and the role of the States parties to progressively ensure full realization of those rights. Article 12 of the ICESCR prescribes steps for the realization of the right to health, which includes those that:

- reduce infant mortality and ensure the healthy development of the child;
- improve environmental and industrial hygiene;
- prevent, treat and control epidemic, endemic, occupational and other diseases; and
- create conditions to ensure access to health care for all.

The UN Committee on Economic, Social and Cultural Rights monitors compliance with the ICESCR. In order to clarify and operationalize the above

provisions, the Committee adopted a General Comment[6] on the Right to Health in 2000.

The General Comment states that the right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

The equal right of the women in health care facilities has been reiterated in the CEDAW. Article 12 of the Convention requires the States Parties to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Paragraph 2 of the same Article emphasizes on the special health rights of the women regarding pregnancy and motherhood. It obliges the States Parties to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. Article 14 further emphasizes on measures to eliminate discrimination against women in rural areas in order to ensure access to adequate health care facilities, including information, counseling and services in family planning.

The CRC is yet another international instrument that emphasized on right to health and medical care, particularly for children. Article 24 of the Convention recognizes the right of the child to the enjoyment of the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health and requires the States Parties to ensure that no child is deprived of his or her right to access to such health care services. It also requires the States Parties to take appropriate measures:

> (a) to diminish infant and child mortality;
>
> (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
>
> (c) to combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the

[6] General Comment 14, UN Committee on Economic, Social and Cultural Rights

provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) to ensure appropriate pre-natal and post-natal health care for mothers;

(e) to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) to develop preventive health care, guidance for parents and family planning education and services.

Paragraph 3 of the same Article provides for all effective and appropriate measures to taken by the States Parties with a view to abolishing traditional practices prejudicial to the health of children, while paragraph 4 emphasized on international co-operation with a view to achieving progressively the full realization of the right recognized in the said Article. Under the Convention the States Parties have a duty to conduct a periodic review of the treatment provided to a child and all other circumstances relevant to his or her placement, when the child has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health (Article 25).

The Declaration of Alma-Ata, 1978 is yet another important document on health rights. This Declaration reaffirmed the World Health Organization's (WHO) definition of health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, and recognized it as a fundamental human right. Article 5 of the Declaration casts a responsibility upon the governments for the health of their people which can be fulfilled only by the provision of adequate health and social measures. This document was mainly focused on primary health care. However, Article 8 of the Declaration is of particular relevance that requires the governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors.

Bangladesh is a party to all these international instruments. As a State party Bangladesh has a responsibility to fulfill its promises under the treaties. In order to ensure that the existing laws and health care services including operation of public and private medical centres, comply with the standards and

protect the rights of the people as enumerated in those instruments, it is essential to review the domestic laws, policies and practices and if necessary, to adopt appropriate measures for necessary changes in the law, policy and practice relating to health care and medical services. The existing laws, policies etc. that govern the health care and medical services are examined in the next segment of this paper.

3.3 National Policies, Statues and Other Legal Documents Relating to Health Care and Medical Services

The policies, statutes and other documents of legal importance that govern the health and medical sector in Bangladesh are discussed here. It is worth mentioning that these policies and laws deal with many different and diverse subject matters, of which only those concerning medical practice, operation of public and private medical centres and regulation of health care services will be attended here. Accountability has always been an issue in the debates relating to medical negligence and operation of private medical clinics. So, specific importance has been given on the provisions of law and policy that can help towards establishing accountability in medical services. The policy that mostly covers the right to health and medical care issues is the National Health Policy (NHP) of 2011. Two other important policies that partly address similar issues are the National Women Development Policy of 2011 and National Child Policy of 1994. Apart from these policies there are a number of statutes that are directly or indirectly linked with medical practice. The laws include:

- The Vaccination Act, 1880
- The Drugs Act, 1940
- The Eye Surgery (Restriction) Ordinance, 1960
- The Pharmacy Ordinance, 1976
- The Drug (Control) Ordinance, 1982
- The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982
- The Bangladesh Unani and Ayurvedic Practitioners Ordinance, 1983
- The Transplant of Organ in Human Body Act, 1999

- The Safe Blood Transfusion Act, 2002
- The Consumer Rights Protection Ordinance, 2008
- The Bangladesh Medical and Dental Council Act, 2010

In addition to these laws, the Penal Code, 1860 also needs to be considered, especially when medical negligence or fraudulent medical practices give rise to criminal liability. Apart from the laws the *Code of Medical Ethics* adopted by Bangladesh Medical and Dental Council, the regulatory body of medical and dental profession in Bangladesh, is of great importance. The relevant provisions of these documents are discussed here followed by an analysis of missing and/or contrary provisions in the policies and laws to ensure accountability and people's right to health and medical care.

3.3.1 National Health Policy, 2011

The National Health Policy, 2011 replaced the previous Policy of 2000. The new Policy in its goals reaffirms Government's commitment to establish treatment as a right as per Constitution and different international instruments. The goals include improvement of quality of service by better management public health care centres and hospitals; to ensure supply of necessary equipments and resources therein, to ensure the quality of service in the private medical colleges, medical education and training institutions, hospitals, clinics and diagnostic centres, to keep the expenses of medical service and education within the rich of the people, to ensure people's right to information regarding health etc. The policy adopted a number of principles to achieve the goals. These principles include -making aware of the citizens without discrimination of any kind to access their right to health, nutrition and medical care, decentralization of medical administration, human resource development, to ensure adequate supply of essential drugs everywhere. The Policy identified the overall challenges in providing medical services; which are poor management, limited resources and low quality of service. It also mentioned the high price of health facilities as a major challenge in the urban area, while it emphasized on providing more health care facilities at upazila and district levels. The Policy in fact, admitted that the overall quality of medical service is not satisfactory to the people at large. Among the reasons, it highlighted inefficiency of the service providers, shortage of medicines, equipments and human resources. The Policy further stressed on the need for quality control of the private medical services and private medical education institutions, and for that purpose emphasized on strengthening State's control over them (NHP, 2011:11). Quite contrary to the

so called culture of denial, the Policy at least admits that due to shortage of human resource, funding and legal aid the regulatory bodies in medical sector are not effective enough. It also proposed for review and modification of the existing policies in this regard (NHP, 2011:12).

The NHP formulated a set of strategies to overcome the challenges and to achieve its goals. It is indeed a plausible aspect of the Policy that it provided for necessary policies and laws to be framed in order to ensure accountability of all involved in providing health care services (NHP, Strategy-14). The strategies also include strengthening of Bangladesh Medical and Dental Council with a view to ensure proper monitoring of registration, professional quality and relevant aspects of ethical practice of medical practitioners. Similarly, Bangladesh Nursing Council will also be restructured (NHP, Strategy-26). Other relevant strategies include improvement of management in the medical colleges and concerned hospitals in order to ensure proper health care service, allowing more financial and administrative powers to the medical colleges and hospitals to perform their overall functions, to ensure quality of service in treatment of patients in every public and private health care centres and to develop a manual on quality of service, monitoring and evaluation method.

3.3.2 National Women Development Policy, 2011

The National Women Development Policy (NWDP) of 2011 deals with a wide range of issues that are directly or indirectly linked to women and their development. Health and nutrition is one of those important issues that the NWDP attempts to address. Among its objectives relating to health and nutrition of women, the Policy (NWDP, 2011:21) declares:

- To ensure rights to nutrition and to have physical and mental health of highest standard all through the life cycle of women i.e. in the childhood, adolescence, during pregnancy and in old age;
- To strengthen primary health care for the women;
- To reduce maternal and child death rates;
- To conduct research to combat the fatal diseases of AIDS and health of women during their pregnancy in particular and publicize health information and raise awareness;
- To educate and train in nutrition;

- To keep in view the matter of reproductive health of the women and reproductive rights in planning population and its implementation;
- To give particular importance to the need of women concerning safe drinking water and sewerage system;
- To ensure participation of women in all the aforesaid services planning, distribution and preservation etc.

Whereas, it is apparent that all of these objectives do not directly relate to medical negligence and fraudulent practices of private clinics, it obviously helps us to perceive the degree of importance attributed to the health and medical issues of women at policy level. Along with other aspects of health and nutrition, risks and hazards involved with pregnancy and child birth are the most common cases that directly affect women. The Policy emphasized on women's right to nutrition and right to health, both physical and mental. However, the NWDP, 2011 does not illustrate any strategic guideline, particularly on women's right to health care and issues of accountability while accessing those rights.

3.3.3 National Children Policy, 1994

The National Children Policy (NCP) of 1994 generally deals with the affairs of children. The Policy specifically addressed the health and nutrition concerns for children in Bangladesh. However, it appears that the NCP did not specifically attend the question of children's right to proper medical care and treatment. The focus was mainly on nutrition and other health aspects. Nevertheless, the Policy adopted the principle of the best interest of the child, which can be an important aid to construction of other legal documents.

3.3.4 The Vaccination Act, 1880

The Vaccination Act, 1940 makes it compulsory for parents or guardians of every child to procure vaccination for the child. Under Section 3 of the Act a public vaccinator is bound to vaccinate a child brought to him. Section 4 of the Act provides for inspection of vaccination. Section 8 states that no fees can be charged for vaccination in a public vaccine station. The Act also provides for penalty for not producing a child for vaccination, for neglect to be vaccinated, for obstructing a public vaccinator in performing his duties etc. The main object of this law was to ensure vaccination of all children. This is not much of relevance so far as medical negligence is concerned.

3.3.5 The Drugs Act, 1940

This law provides for establishment of a central drug laboratory by the Government to carry out the functions entrusted to it by this Act (Section 6). Section 9 of the Act provides for misbranded drugs. In case of imported drugs, a drug shall be deemed to be misbranded if it falls under any of the heads mentioned in the said Section e.g. if it is an imitation, or if it makes false statement etc. Section 10 of the Act prohibits import of certain drugs; such as drugs which are not of standard quality, or misbranded drugs etc. Contravening with any provision relating to import of drugs is punishable under Section 13, for which the maximum punishment is imprisonment of one year or fine of Taka 500 or both. Section 14 also provides for confiscation of such drugs. Section 18 of the Act prohibits manufacturing and sale of certain drugs e.g. drugs which are not of standard quality, misbranded drugs etc.

An Inspector may be appointed by the Government under Section 21 for the purpose of inspecting the manufacture, sale and distribution of drugs. Section 22 describes the powers of the Inspector. His powers include inspecting plant, machinery, registers, records, stocks; enter into and search any place when he has reasonable belief that any act in contravention to this Act has been or being committed there: lock and seal any factory, laboratory, shop, building or godown. Section 26 of the Act is very significant. It enables any person to submit for test or analysis to a Government Analyst and to receive a report of such test or analysis. The Act also provides for penalty for manufacture, sale etc. of drugs in contravention of the Act (Section 27), for giving false warranty or misuse of warranty (Section 28) etc.

3.3.6 The Eye Surgery (Restriction) Ordinance, 1960

This Ordinance restricts eye surgery by a person who is not a registered medical practitioner. Section 3 of the Ordinance states that any person, not being a registered medical practitioner, who performs eye surgery upon another, whether with or without the latter's consent, shall be punishable with imprisonment for a term which may extend to one year, and with fine which may extend to one thousand taka (Sub-section 1). Sub-section 2 of the same Section further provides that the term of imprisonment under sub-section (1) may extend-

(a) to three years, if the offence results in partial blindness, and

(b) to seven years , if the offence results in complete blindness.

3.3.17 The Pharmacy Ordinance, 1976

The object of this Ordinance was to regulate the practice of pharmacy in Bangladesh. Section 3 of the Ordinance provided for establishment of a council to be known as Bangladesh Pharmacy Council. The composition of the Council, headed by the Secretary, Ministry of Health (ex officio) and including a professor of medicine, a professor of pharmacology and pharmacists nominated by different associations, is set forth in Section 4. Section 17 describes the functions of the Council, which are inter alia-

(a) to approve examinations in Pharmacy for the purpose of qualifying persons or registration as pharmacists;

(b) to prescribe the subjects in which approved examinations shall be held;

(c) to approve the courses of study and practical training in pharmacy for the purpose of admission to approved examinations;

(d) to prescribe the conditions and procedure for admission of candidates to an approved examination;

(e) to lay down the standard of teaching to be maintained by institutions conducting the approved courses of study;

(f) to prescribe the equipment and facilities to be made available to the students;

(g) to recognize degree or diploma in Pharmacy for the purpose of registration as pharmacists;

(h) to cause inspection of institutions which conduct any course of study in Pharmacy and of the teachings imparted and examinations held by them;

(i) to prepare and maintain Registers of pharmacists and apprentices in pharmacy;

(j) to register pharmacists and grant certificates of registration;

(k) to hold examinations for the purpose of registration as pharmacists; and

(l) to do such other acts and things as it may be empowered or required to do by or under the Ordinance.

Section 21 of the Ordinance empowers the Council to appoint Inspectors who, with such authorization from the President of the Council, can inspect any institution which holds an approved examination or conducts an approved course of study and may attend any such examination held by such institutions and inspect any institution which has applied for the approval of the examination held, or course of study conducted. Section 28 provides for examination for registration of pharmacists, while Section 29 sets the qualification for admission into such examination. Section 30 prohibits practicing without registration and also requires a registered pharmacist to display his certificate of registration in a conspicuous place within the premises in which he practises. Any contravention to this provision is an offence which on first conviction, is punishable with fine which may extend to Taka five hundred, and, on each subsequent conviction with imprisonment for a term which may extend to three months, or with fine which may extend to Taka five hundred, or with both.

3.3.18 The Drug (Control) Ordinance, 1982

This Ordinance was promulgated with a view to control manufacture, import, distribution and sale of drugs in Bangladesh. Section 5 of the Ordinance provides for registration of medicines. The Section reads, no medicine of any kind shall be manufactured for sale or be imported, distributed or sold unless it is registered with the licensing authority. A registration shall be granted on the conditions as may be prescribed by the licensing authority. Under Section 6 of the Ordinance, the licensing authority may cancel the registration of any medicine if such cancellation is recommended by the Drug Control Committee. The Committee shall evaluate every medicine that may be manufactured or imported, to determine its safety, efficacy and usefulness. On such evaluation of a medicine, if it is found that such medicine is not safe, the Committee may recommend to the licensing authority for cancellation of the registration of the medicine; or if the medicine is sub-standard, the licensing authority may suspend the registration of such medicine till it is satisfied that the medicine has attained its standard.

Section 15 of the Ordinance requires every manufacturer of drugs to follow the good practices in manufacturing and quality control of drugs recommended by the World Health Organization. If any manufacturer does not follow the practices, his license may be cancelled or suspended. Sections 17, 19 and 21 set penalties for manufacturing sub-standard medicine, for sale of drugs at a higher price than the maximum price fixed by the Government and for illegal advertisement and claims respectively.

3.3.19 The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982

This Ordinance is intended to regulate medical practice and functioning of private clinics and laboratories. This is a vital law in dealing with private medical services as it provides for regulation of private practice, private clinics and laboratories. Section 4 of the Ordinance prohibits a registered medical practitioner in service of the Republic to carry on private medical practice during office hours. As per Section 5 all medical practitioners are required to maintain hygienically sound chamber and room for the examination of patients. Section 9 lays down the conditions for licensing of private clinics. According to the Section every private clinics have to ensure arrangement of requisite facilities, which are inter alia:

(a) proper accommodation with hygienic environment;

(b) at least eighty square feet floor space for each patient;

(c) an air-conditioned operation theatre;

(d) essential equipments as specified in Schedule B of the Ordinance;

(e) adequate supply of life saving drugs and medicines;

(f) such number of full time registered medical practitioners, nurses and other staffs as are specified in Schedule C;

(g) specialists for the operation, treatment and supervision of patients.

Section 11 provides for inspection. The Director General of Health or any officer authorized by him in this behalf may inspect any private medical chamber, clinic, or laboratory. If any chamber, clinic or laboratory is found to have contravened any provision of the Ordinance, the Director General may recommend to the Government to debar the medical practitioner from carrying on private practice; or in case of clinic, may cancel the license; or in case of laboratory, may recommend to the Government to close down the laboratory. Contravention of any provision of this Ordinance by a medical practitioner or private laboratory is punishable with fine which may extend to Taka five thousand, whereas contravention of any provisions by the owner of a private medical clinic is punishable with imprisonment for a term which may extend to six months or fine which may extend to Taka five thousand or with both. In both cases, the Court, while convicting the owner of a private clinic or laboratory, may order forfeiture of all or any of its movable property to the Government. Schedule A of the Ordinance shows the maximum fees for medical consultation, surgical operations, deliveries, ECG; and also the maximum fees for laboratory investigations.

3.3.20 The Bangladesh Unani and Ayurvedic Practitioners Ordinance, 1983

This law regulates the qualification and registration of practitioners of Unani and Ayurvedic systems[7] of medicine. Section 3 provides for establishment of a board to be called the Bangladesh Board of Unani and Ayurvedic systems of medicine for carrying out the purposes of this Ordinance. Section 4 describes the composition of the Board which contains, inter alia (a) a Chairman to be appointed by the Government; (b) two members to be nominated by the Government, of whom one each shall be from amongst the practising Hakims and Vaids;(c) one member from each administrative division to be elected by the registered practitioners of Unani system of medicine from amongst themselves; (d) one member from each administrative division to be elected by the registered practitioners of the Ayurvedic system of medicine from amongst themselves; (e) two members to be nominated by the Government from amongst the teachers of recognised teaching institutions of Unani and Ayurvedic systems of medicine. Section 13 of the Ordinance lists the functions of the Board that include:

> (a) to consider applications for recognition under this Ordinance made by institutions imparting or desiring to impart instruction in the Unani or Ayurvedic systems of medicine;
>
> (b) to secure the maintenance of an adequate standard of efficiency in recognised institutions;
>
> (c) to make arrangement for the registrations of duly qualified persons in accordance with the provisions of this Ordinance;
>
> (e) to hold examinations and confer certificates, diplomas or degrees in Unani and Ayurvedic systems of medicine;
>
> (g) to make arrangements for standardisation of the Unani and Ayurvedic medicines;
>
> (j) to prepare and publish Unani and Ayurvedic Pharmacopoeia and Code of Ethics for practitioners registered under this Ordinance;
>
> (p) to do such other acts and things as it may be empowered or required to do by this Ordinance or the rules.

[7] Unani and Ayurvedic systems are the two traditional disciplines of medicine, mainly based on herbal treatment.

Sub-section 3 of Section 30 requires that a registered Unani or Ayurvedic practitioner shall abide by the Code of Ethics for Unani and Ayurvedic practitioners framed by the Board and approved by the Government. Contravention of this provision is punishable under Section 31, with imprisonment for a term which may extend to one year, or with fine which may extend to Taka one thousand, or with both. Section 34 prohibits use of false title, description, deceptive abbreviation; violation of which is also punishable as above.

3.3.21 The Transplant of Organ in Human Body Act, 1999

This Act intends to regulate collection and preservation of organs for transplantation and to ensure its lawful use. Section 3 provides for donation of such organ by a living person of sound mind to any of his close relatives, severance of which will not impair his normal life. However, there are certain restrictions to such donation, which are stated in the proviso of the said Section e.g. a person below the age of eighteen is not allowed to donate except in case of regenerative tissue or any person who is declared unfit by the Medical Board for such donation. Conditions for removing an organ from the dead body of a person are described in Section 4 of the Act. Section 7 provides for formation of medical board by the Government in every medical institution, where such transplantation of human organs is carried out. Section 9 of the Act makes it illegal to purchase or sale any human organ. Violation or abetment in violation of any of the provisions of this Act is punishable under Section 10 with rigorous imprisonment for a term not less than three years and not exceeding ten years, or with fine, not less than Taka three hundred thousand, or with both. If any physician is found guilty of any such offence, then in addition to the aforesaid punishment his registration as a physician will liable to be cancelled.

3.3.22 The Safe Blood Transfusion Act, 2002

This law is aimed to regulate collection, preservation and transfusion of safe blood. Section 4 of the Act provides for establishment of National Safe Blood Transfusion Council. The duties and responsibilities of the Council are set forth in Section 5. The Council is endowed with the power and responsibility to frame policies on protection against blood-transmitted diseases and germs like Human Immuno Deficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Malaria and Syphilis; policy for encouraging voluntary blood donation, for control of private blood transfusion centres; for operation of blood transfusion centres in the public hospitals. Section 9 of the Act sets the procedure for licensing of private blood transfusion centres. The Director General of Health is the licensing authority under Section 10. One or more inspection committee can be formed by the Government under Section 15

to inspect the private blood transfusion centres. Chapter IV of the Act deals with offences and their punishments relating to blood transfusion. The offences include establishing and operating private blood transfusion centres without obtaining a license as per provisions of this Act (Section 18), transfusion of blood in an unsafe method (Section 20), non-disposal (Section 21) and reuse (Section 22) of disposable items, transfusion of blood without prior test (Section 23), transfusion of blood by an unauthorised person (Section 25), receiving excess service charge (Section 27) etc. Section 31 deals with offences committed by a company.

3.3.23 The Consumer Rights Protection Ordinance, 2008

Under Section 76 of the Ordinance the Director General of Consumer Rights Protection Department can inspect any private health care centre to check out if there is any deviation or violation of law. If he finds any deviation or non-compliance he shall immediately inform the Secretary, Ministry of Health or the Director General of Health; but he has no power to directly take any action in this regard. Section 52 provides punishment for unlawful acts endangering life or personal safety of the consumer; whereas Section 53 provides punishment for loss of money, health or life of the consumer due to negligence, irresponsibility or carelessness of the service provider. Both offences are punishable with imprisonment for a term not exceeding three years, or fine not exceeding taka two thousand, or with both. Section 69 provides for civil remedy for compensation, independently of any criminal case. The civil courts are empowered by Section 70 to award compensation up to the sum equal to five times of the actual damage caused and other reliefs in a proceeding for compensation due to negligence.

3.3.24 The Bangladesh Medical and Dental Council Act, 2010

This Act replaced the previous Medical and Dental Council Act of 1980. Section 4 provides for formation of the Council which include eight Members of the Parliament to be nominated by the Speaker, the Director General of Health (ex-officio), the Vice-Chancellor of Bangabandhu Sheikh Mujib Medical University (ex-officio) and other ex-officio and nominated members from different institutions and associations. Section 5 describes the powers and responsibilities of the Council. The powers and responsibilities are inter alia to grant accreditation to medical and dental education provided in medical and dental institutions in and outside Bangladesh; to set the policies and conditions for admission into medical and dental institutions; to administrate registration of recognized medical and dental professionals, and medical assistants; to prepare, publish and maintain such registers; to inspect medical and dental institutions, to take punitive measures against persons who are engaged in medical profession without registration under this Act; to

take punitive measures against use of false title, degree, fraudulent misrepresentation etc; to adopt code of professional conduct and ethics for medical and dental professionals and such other or further acts as may be necessary for or incidental to fulfillment of other responsibilities.

Section 17 of the Act provides for withdrawal of accreditation granted to a medical institution if the syllabus, examinations or proficiency of the students of that institute, who attended such examinations do not meet the required standard. Section 18 and 19 respectively deal with registration of recognized physicians and dentists; while Section 20 provides for registration of professional medical assistants. According to Section 21, the registers prepared, published and maintained under Sections 18, 19 and 20 shall be considered as public documents under the meaning of the Evidence Act, 1872.

Section 22 of the Act prohibits the practice of allopathic medicine, or introduction of oneself as a physician or a dentist; without registration under this Act. Violation of this provision is punishable with imprisonment which may extend to three years or with fine which may extend to Taka 1 lac or both. Section 23 provides for cancellation of registration of any registered physician, dentist or medical assistant, if they are found guilty of any misconduct or violate any provisions of this Act. Under Section 24, an appeal can be preferred against such cancellation. Section 27 provides for inspection of any medical or dental institution in order to evaluate the syllabus, method of examinations, training and other relevant activities. Any fraudulent claim by a person to be a registered physician or dentist or any fraudulent misrepresentation to that effect is punishable with imprisonment for a term of three years or fine of Taka one lac or with both, as per Section 28. Section 29 provides punishment for using false title etc., whereas Section 30 provides punishment for prescribing banned medicines.

3.3.25 The Code of Medical Ethics

The Code of Medical Ethics adopted[8] by the BMDC sets the normative guidelines of professional conduct to be followed by the registered physicians and dentists. Amongst other instructions and prohibitions, the guidelines prohibits issue of certificate containing false statements; attempt to make improper profit; abuse of professional knowledge, skill or privileges;

[8] This Code has been adopted by the BMDC in its meeting held on 24.03.1983 under the provisions of the Medical and Dental Council Act of 1980 which, now has been replaced with the Medical and Dental Council Act, 2010. Nevertheless, the Code remains in force as per savings clause (Section 38(3)(a)) of the Act of 2010, since no change, modification or replacement has been made so far under the new Act of 2010.

abuse of patient relationship; canvassing, advertising and using false title etc. The guidelines also address disregard of personal responsibility to the patient. It states:

> "5. (a) Gross negligence in respect of his professional duties to his patient may be regarded as misconduct sufficient to justify the suspension or removal of the name of a Medical/Dental Practitioner from the Register.
>
> (b) Assisting an unregistered person to practice medicine or dentistry etc., or a professional association with such a person performing the functions of a practitioner in relation to medicine, surgery and midwifery, dentistry etc.; knowingly will make a registered practitioner liable to disciplinary action. ..."

However, the Code does not specifically set any standard for degree of care that a medical or dental practitioner owes to the patient; it only addresses gross negligence and unauthorized professional association.

3.3.26 Penal Law in General: The Penal Code, 1860

Depending on the nature and culpability of the alleged act, medical negligence and fraudulent or ill practices involving medical profession or service can also come within the purview of general penal law[9]. The Penal Code of 1860 is the main penal law of Bangladesh that generally deals with different types of criminal offences. The offences under the Penal Code are tried in the criminal courts according to the provisions of the Code of Criminal Procedure, 1898.

The Penal Code, however, does not contain any specific section to particularly address culpable negligence of a medical practitioner, except those relating to causing miscarriage etc. Nevertheless, the following sections of the Penal Code are of some relevance in cases of medical negligence, acts threatening public health, fraudulent conduct and so on. The sections are mentioned below with their short title:

Sections	Short Title of the Section/Offence
269	Negligent act likely to spread infection of disease dangerous to life

[9] The last chapter of the ASK publication *Chikitshay Obohela*, December 2008 contains a number of articles offering elaborate discussions on the provisions of the Penal Code, 1860 available in case of medical negligence and related/similar wrongs.

270	Malignant act likely to spread infection of disease dangerous to life
271	Disobedience to quarantine rule
272	Adulteration of food or drink intended for sale
273	Sale of noxious food or drink
274	Adulteration of drugs
275	Sale of adulterated drugs
276	Sale of drug as a different drug or preparation
304A	Causing death by negligence
312	Causing miscarriage
313	Causing miscarriage without women's consent
314	Death caused by act done with intent to cause miscarriage
315	Act done with intent to prevent child being born alive or to cause it to die after birth
316	Causing death of quick unborn child by act amounting to culpable homicide
336	Act endangering life or personal safety to others
337	Causing hurt by act endangering life or personal safety to others
338	Causing grievous hurt by act endangering life or personal safety to others
415	Cheating
416	Cheating by personation
418	Cheating with knowledge that wrongful loss may ensue to person whose interest the offender is bound to protect

Among the abovementioned offences the Sections regarding Cheating or Cheating by personation etc. can be applied in cases of fraudulent practices of private clinics and medical centres. Prescribing patients for inappropriate and unnecessary medical tests can be brought under the mischief of Section 418.

On the other hand, certain provisions of the Penal Code provides immunity for acts done in good faith, which again serves as an impediment to application of most of these sections. Section 88 states:

> "**Act not intended to cause death, done by consent in good faith for person's benefit**
>
> 88. Nothing, which is not intended 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 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"

Section 91 provides for inapplicability of Section 88. The immunity of Section 88 shall not apply when the very act done, itself is an offence; such as causing miscarriage (unless done in good faith for saving the life of the woman). Section 92 of the Penal Code, further absolves criminal liability for acts done in good faith, in certain circumstances where it is impossible to obtain consent or where the person is incapable of giving so.

3.4 Gap Analysis: Contrary or Missing Provisions in the Laws and Policies

The Constitution of Bangladesh recognizes right to health and treatment. From the experience of judicial review and PILs in Bangladesh; the constitutional jurisprudence developed so far has left the debate regarding

enforceability of ESC rights recognized as 'fundamental principles of State policy' more of an academic importance. However, it cannot be denied that an express recognition as 'fundamental rights' could create a broader avenue to enforce those rights. Lack of resource has always been a common justification for not to make ensuring those rights binding upon the State. Keeping aside the merit of the question that how long this 'crisis argument' would continue to sustain in the constitutional cases yet after forty two years from independence; the constitutional safeguards coupled with other fundamental rights and with the aid of judicial intervention including PIL, are quite capable of according protection against medical negligence and like vices, if not enforcing the right to health in its entirety.

The NHP of 2011 unequivocally emphasized on the need for quality control of the private medical services and private medical education institutions, which is a time worthy decision. In addition to this, it is more promising for the NHP to provide for necessary policies and laws to be framed in order to ensure accountability of all involved in providing health care services (NHP, Strategy-14). The NHP also envisioned strengthening of Bangladesh Medical and Dental Council with a view to ensure proper monitoring of registration, professional quality and relevant aspects of ethical practice of medical practitioners. While, these are undoubtedly some plausible aspects of the NHP, the question follows is the more typical one as to how far these policies would be translated in implementation. The NHP itself, however, does not contain any time bound plan of action to achieve its goals. The NWDP and the NCP addresses right to health from their own perspectives. But, the NWDP particularly is devoid of any pragmatic vision to ensure accountability in obtaining maternity care and other medical services relating to child birth, which has been a major issue of women's sufferings, both in rural and urban areas of Bangladesh.

Among the laws discussed in this part the Vaccination Act, 1880; the Eye Surgery (Restriction) Ordinance, 1960; the Transplant of Organ in Human Body Act, 1999 and the Safe Blood Transfusion Act, 2002 deals with specific issues of health and medical care. These statutes generally cover their concerned areas and also provide for punishments in cases of violations of the statutory provisions. The Drugs Act, 1940; the Pharmacy Ordinance, 1976 and the Drug (Control) Ordinance, 1982 regulate the manufacturing, import, distribution and sale of drugs and medicines, one of the most essential elements of treatment. The provisions of these laws are apparently in line with the constitutional safeguards and international standard; but the compliance monitoring systems under the laws need to be improved and more importantly, proper documentation and accessibility of information regarding actions taken is due from the Government.

The Bangladesh Unani and Ayurvedic Practitioners Ordinance, 1983 regulates the practice of Unani and Ayurvedic systems of medicine. The provisions of the Ordinance regarding monitoring or Unani and Ayurvedic practice seem adequate. It needs to be mentioned that these forms of alternative medicines have also been given importance in the NHP. The Bangladesh Medical and Dental Council Act, 2010 regulates the profession and registration of medical and dental practitioners and medical assistants and this sector is one of the major areas of this study. Under the Act, the BMDC is empowered and responsible for registration and monitoring of the practice of the medical and dental practitioners. The BMDC has the power to take action against a registered physician or dentist if he is found guilty of any misconduct. But what constitutes misconduct, is not defined in the Act. The Act also fails to specifically address the issue of medical negligence and set the standard for duty of care that a medical practitioner owes to the patients. Although the Act empowered the BMDC to take action against a registered physician or dentist, unlike the Bangladesh Legal Practitioner and Bar Council Order, 1972[10] it did not specifically provide for any tribunal to adjudicate the complaints against the medical practitioners. Such a provision is clearly missing in the Act. A permanent forum to formally deal with disciplinary actions against medical practitioners is essential for a transparent and effective disposal of complaints. The Code of Medical Ethics again, only address gross negligence and that is also in vague way. It utterly fails to categorically illustrate the duties and responsibilities of a medical practitioner with regard to different aspects of his profession. It is also frustrating that the Code does not make any attempt to ascertain the degree of liability to be attached to different types of negligence. Legally and technically, the BMDC is the best authority to develop such an index that requires both specialized knowledge of medical science and lawful authority, which the BMDC definitely has, to go through the intricacies and develop a set of standard.

The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982 provide for certain measures in order to monitor the activities of the private clinics and laboratories. The Ordinance also specifically provided for the essential requirement that private clinics or laboratories have to ensure in order to obtain license and carry on their business. The Director General of Health is mainly responsible for the monitoring. The provisions of the ordinance appear to be sound. But the problem remains with application. So, the question that is important to consider at this stage is whether there is anything missing in the law which

[10] This law regulates the professional aspects of legal practitioners in Bangladesh. The Order provided for formation and procedure of a tribunal to adjudicate any complaint against a legal practitioner on the ground of professional misconduct and malpractice.

can ensure proper application. It seems that whereas the Director General of Health is empowered to take necessary actions for monitoring etc., there is nothing in the Ordinance to ensure his accountability. This aspect needs to be taken into consideration in order to establish accountability of the monitoring mechanism in the first place.

The provisions of the Penal Code, 1860, as mentioned in this part are the general penal provisions relating to public health, cheating etc. Among those provisions Sections 304A and Sections 312-316 can be directly invoked in cases of medical negligence. But still, the immunity granted by Sections 88 and 92 are the main hurdle to prove a case of medical negligence. It is all the more difficult because of the fact that in any case of medical negligence, it is very hard to establish the requisite *mens rea* or mental element as the doctor-patient relationship itself carries a presumption of acting in good faith and not *malafide*. As a result, even the cases of gross negligence do not appropriately fit to the scope of those sections. On the contrary, the immunity accorded by Sections 88 and 92 are also necessary to protect a person who acts in good faith while discharging his professional duties. The incidents of fraudulent activities of private clinics or individuals can well be addressed under Sections 416 and 418 of the Penal Code.

The Consumer Rights Protection Ordinance, 2008 being a new law, instances of seeking remedy under the Ordinance have not been reported well yet. But, there is a promising prospect of this law, which simultaneously provides for criminal and civil action against negligence of the service provider.

3.5 Initiative for legal Reform: Bangladesh Law Commission's Proposals

From the above analysis it is apparent that the legal regime in Bangladesh lacks specific legislation on medical negligence. At present there is no law that specifically defines medical negligence. Doctor's negligence being a matter of a specialized discipline, cannot be generally construed as in other cases by the courts or lawyers. Therefore, a specific legislation defining what medical negligence is, and also setting the parameters of medical negligence is essential. The NHP, 2011 itself provided for necessary changes in the laws and regulations to ensure accountability in medical sector. Emphasizing the need for a specific law on medical negligence in Bangladesh, the Law Commission, under the chairmanship of Professor Dr. Shah Alam has prepared a set of proposals to appropriately address medical negligence. The suggestions of the Law Commission include:

i) Medical negligence is to be properly defined with its nature and uniqueness. To determine such matter a committee composed of doctors, experts and citizen representatives may be formed.

ii) The relation between doctors and the pathologies and diagnostic centers needs to be revisited.

iii) Proper management of the privately and government owned hospitals would reduce the case of negligence.

iv) Special type of civil courts to redress the negligence issue by way of awarding compensation and alternative dispute resolution may be constituted.

v) An avenue to go to BMDC may be opened as a prior step of resorting to court. In that case, the constitution, powers and functions of BMDC may be remodeled and reformulated.

vi) The hospitals or medical centers will have to take vicarious liability for the works of doctors, assistants and all other staffs.

vii) The government is to fulfill its constitutional and human rights obligation to ensure the right to health of the people by recruiting more doctors, supplying modern technological appliances etc.

viii) Medical ethics should be studied with more importance in the medical curricula.

Part IV

Remedy against Medical Negligence and Fraudulent Practices of Private Clinics Available under the Existing Law and Practice in Bangladesh

Medical negligence can legally be addressed in a number of ways. Any case of medical negligence or malpractice obviously involves a breach of duty. This breach can be redressed by civil remedy, such as compensation. In cases where the negligence is culpable, then criminal action can also sustain. In addition to that as medical negligence and malpractice essentially contain elements of breach of a professional duty, it comes within the purview of professional misconduct and hence, liable to departmental or disciplinary actions. Different laws that regulate the medical services in Bangladesh define offences relating to the concerned subject matter and also provides for punishment for those offences. Therefore, actions can be taken under those specific legislations also. Finally, action can be taken commonly on behalf of the people through PIL or employing other means of judicial review, such as writ petition. In this part the remedies available under the existing laws that can be resorted to in cases of medical negligence have been categorically discussed.

4.1 Departmental/Disciplinary Action

The BMDC being the regulatory body of medical and dental profession is entrusted with the power to take disciplinary actions against a registered physician or dentist. Under Section 23 of the Medical and Dental Council Act, 2010 the BMDC can cancel the registration of any registered physician, dentist or medical assistant, if they are found guilty of any misconduct or violate any provisions of the Act. This provision could be a very effective tool for the BMDC to bring in accountability in medical and dental profession. But, unfortunately in practice, the BMDC seems reluctant to recognize negligence as misconduct. The Code of Medical Ethics only states gross negligence and that again, not necessarily to be construed as misconduct, since it uses the word "may". It appears that the Code did not intend to include the negligence which is *prima facie* not gross in nature. There is nothing in the Code to further explain what amounts to gross negligence; and what does not. So, ultimately the scope of departmental/disciplinary actions becomes too narrow due to these inconsistencies.

4.2 Criminal Action

The scope for criminal action for medical negligence is also very limited. The difficulties in proving doctor's guilt in a criminal court has been discussed in

the preceding part. There are very few Sections in the Penal Code that can be applied in cases of medical negligence. The offences described in the Penal Code typically have a strong emphasis on *mens rea* or guilty mind. In a case of medical negligence, where admittedly it all starts with an attempt to cure the patient, the very context itself presupposes a good faith, and therefore, it is always very difficult to establish the underlying elements of a crime. It can be argued that in such cases *mens rea* need not be proved, or alternatively that instead of actual guilty mind, knowledge of the probable injury/loss or constructive *mens rea* should suffice. But that is not possible and practicable to apply, particularly when prosecuting medical negligence under the Penal Code; where by virtue of his profession the doctor always has to take certain risks, obviously with knowledge, with or without consent of his patient. The immunity as provided in Sections 88 and 92 of the Penal Code is founded on this reasoning, which cannot be ignored or opposed in order to maintain the balance of fairness.

Apart from the legal challenges, there are also practical difficulties with the criminal procedure to prove a case of medical negligence. First of all, the investigation is to be carried out by the police who apparently lack proper expertise and resources to investigate a case of medical negligence. Due to inefficiency of the court administration and other support services; such as not delivering viscera report in time, not preserving the evidence properly, it becomes very difficult to conduct the case in a smooth way. The lawyers and judges also lack in requisite knowledge and expertise to deal with a case of medical negligence. Although the criminal cases are normally supposed to be conducted by the public prosecutors, it is generally observed in all cases that a criminal case does not move forward in a reasonable speed, unless the victim appoints his own lawyer or can afford speed money for the public prosecutors. Such kind of troubles ultimately discourages the poor victims to continue. The back log of cases, lengthy proceedings, corruption in the entire system and inefficiency of the court administration makes it nearly impossible to successfully end up with a criminal case for medical negligence.

The statutes discussed in the Part III, which regulate different aspects of medical services and health care, contain penal provisions. The offences under those statutes are also to be tried under the criminal procedure. But for that, unlike other general offences, the criminal proceeding is supposed to be initiated by the respective monitoring authority under those laws.

4.3 Civil Suit for Compensation

Civil suit for compensation is generally maintainable for all instances of medical negligence. Section 9 of the Code of Civil Procedure (CPC), 1908

empowers the civil courts to try all suits of a civil nature, unless expressly or impliedly barred by law. Section 19 further provides:

> "Where a suit is for compensation for wrong done to the person or to movable property, if the wrong was done within the local limits of the jurisdiction of one Court and the defendant resides, or carries on business, or personally works for gain, within the local limits of the jurisdiction of another Court, the suit may be instituted at the option of the plaintiff in either of the said Courts."

Therefore, suit for compensation could be a suitable remedy for medical negligence, since there is no express or implied legal restriction. But, the instances of civil litigation are also very rare regarding medical negligence. There are certain factors that discourage civil litigation for compensation; such as:

- Advalorem court fee is required to file a suit for compensation;
- Other expenses of litigation, such as lawyers' fees etc.;
- Lengthy court proceeding;
- Lack of technical knowledge and expertise of the lawyers and judges;
- Stringent provisions of the Evidence Act, 1872;
- Inefficiency of the court administration and judicial infrastructure;
- Generally, strong sense of confusion prevailing in the lower courts as to maintainability and success of such proceedings;

It is worth mentioning that although the CPC provides for suit for compensation and there is no substantive legislation that specifically addresses compensation for medical negligence. Therefore, in absence of a developed tort law, the lawyers, courts and the litigants feel unconfident to opt for a civil suit. However, the application of law of tort and its well-established principles are not barred by any law. Therefore, it can be concluded that civil suit for compensation has mostly remained an unexplored avenue in seeking remedy for medical negligence.

4.4 Remedies under the Consumer Rights Protection Ordinance, 2008

Sections 52 and 53 of the Ordinance provide for punishment of the service providers in cases of negligence etc. The Ordinance, at the same time, also provided for parallel civil jurisdiction. A civil action for compensation under the Ordinance is maintainable independently of the criminal case. The court of Joint District Judge of the concerned local jurisdiction is the court of first instance. An appeal can only be preferred to the High Court Division of the Supreme Court. Along with other powers, the Court can award the plaintiff compensation up to five times of the actual loss.

The question whether medical negligence can be addressed within the scope of this Ordinance is also vital. An Indian case can be of most relevance. The Supreme Court of India in *Indian Medical Association Vs. VP Shantha*[11] held that medical profession comes within the meaning of 'service' as defined in the Consumer Protection Act, 1986. As a result, the legal complications for in redressing medical negligence through actions under the Consumer Protection Act were removed. The judgement defined the relationship between patients and medical professionals as contractual. The Court held that even though services rendered by medical practitioners are of a personal nature they cannot be treated as contracts of personal service, which are excluded from the Consumer Protection Act. They are contracts for service and fall within the ambit of the Act. The main relief provided under the Act is compensation for the damage caused due to deficiency in service, which in the case of medical services is negligence.

4.5 Judicial Review

Judicial review, whether in PILs or in other writ cases, can provide certain remedy regarding medical negligence. The remedy accorded by judicial review may not directly benefit an individual but it does have a collective impact on the issue. Judicial review can have multiple impacts on a particular issue. The High Court Division of the Supreme Court has the power of judicial review under Article 102 of the Constitution. The failure of the State mechanisms to fulfill their legal and constitutional obligations is an obvious ground where the Court can intervene in exercise of its power of judicial review. Apart from providing individual remedy where there is no other equally efficacious remedy available under the law; judicial review can also provide for prospective collective remedy or open the sealed doors of procedural relief.

[11] AIR 1996 SC 550: (1995) 6 SCC 651

Part V

Remedy against Medical Negligence and Fraudulent Medical Practices: A Comparative Study of Different National Jurisdictions

This part intends to endeavour the experience of other countries in providing remedy against medical negligence. The countries like India, Nepal and Malaysia which are relatively more similar and nearer to Bangladesh in terms of ethno-graphic, financial and educational aspects have been chosen here for a comparative discussion. This part will first assess the remedies available in the laws and practices of different national jurisdictions, and then evaluate the achievements of civil society movement, judicial initiatives and activism on this particular field by way of judicial review, Public Interest Litigation (PIL) and so on.

5.1 Available Remedies in Law and Practice

Medical negligence and proper management and monitoring of private health care services are matters of serious concern for all developing countries. Therefore, it is all the more important to study the systemic response of these countries to address the issue. This segment analyzes the remedies generally available in the existing systems of the countries concerned. Thus, 'law and practice' here, indicate to the entire arrangement including statutes, rules, bye-laws, legal and institutional frame works, in which, a remedy is not only apparently visible but also practically accessible.

5.1.1 The Experience of India

In India, remedy for medical negligence is available under two different statutes: Indian Penal Code (IPC), 1860 and Consumers Protection Act (CPA), 1986. This segment will discuss the scope of the IPC and the CPA; and will also describe the remedies available in India under these laws.

5.1.1.1 Remedy under Indian Penal Code

Section 304A of IPC covers acts of medical professionals. According to this Section, whoever causes the death of the person due to negligence or a rash act, not amounting to culpable homicide, can be tried and suitably punished with imprisonment for 2 years or fine or both. Sections 52, 80, 81, 83, 88, 90, 91, 92 304-A, 337 and 338 all cover the acts of medical malpractice.

5.1.1.2 Remedy under Consumers Protection Act, 1986

A consumer or any recognized consumer association, i.e., voluntary consumer association registered under the Companies Act, 1956 or any other law for the time being in force, whether the consumer is a member of such association or not, or the central or state government.

The Act defines consumer as a person who hires or avails of any services for a consideration that has been paid or promised or partly paid and partly promised or under any system of deferred payment and includes any beneficiary of such services other than the person hires or avails of the services for consideration paid or promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person. This definition is wide enough to include a patient who merely promises to pay.

A consumer can file a complaint on the ground that he or she has suffered loss or damage as a result of any deficiency of service. Deficiency of service means any fault, imperfection, shortcoming, or inadequacy in the quality, nature, or manner of performance that is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.

A complaint under the Act can be filed in 1) the District Forum if the value of services and compensation claimed is less than 20 lakh Rupees, 2) before the State Commission, if the value of the goods or services and the compensation claimed is more than 20 lac Ruppes, does not exceed more than 1 crore Rupees, or 3) in the National Commission, if the value of the goods or services and the compensation exceeds more than 1 crore Rupees.

There is a minimal fee for filing a complaint before the district consumer redressal forums. An appeal against the decision of the District Forum can be filed before the State Commission. An appeal will then go from the State Commission to the National Commission and from the National Commission to the Supreme Court. The time limit within which the appeal should be filed is 30 days from the date of the decision in all cases.

The forums have a wide range of powers. They are 1) the summoning and enforcing of the attendance of any defendant or witness and examining the witness under oath, 2) the discovery and production of any document or other material object producible as evidence, 3) the reception of evidence

on affidavits, 4) the summoning of any expert evidence or testimony, 5) the requisitioning of the report of the concerned analysis or test from the appropriate laboratory or from any other relevant source, 6) issuing of any commission for the examination of any witness, and 7) any other matter which may be prescribed.

The process before the competent forum will be set in motion in the following manner. When the Complainant files a written complaint, the forum, after admitting the complaint, sends a written notice to the opposite party asking for a written version to be submitted within 30 days. Thereafter, subsequent to proper scrutiny, the forum would ask for either filing of an affidavit or production of evidence in the form of interrogatories, expert evidence, medical literature, and judicial decisions.

5.1.2 Experience of Nepal

In Nepal, medical practice is controlled by Code of Medical Ethics, Nepal Medical Council Act, 1964, Nepal Medical Council Rules, 1968 and Consumer Protection Act, 1998. Section 22 of Code of Medical Ethics, requires a doctor to treat the disease by making a proper diagnosis with his/her full intelligence and capability. As per Rule 23 of the Nepal Medical Council Rules 1968, action can be taken if the Code of Conduct mentioned above is found to have been violated. The rules mention that the medical practitioner's name can be removed from the registration book upon proof of violation of the Code of Conduct and voting thereafter. Section 17 (b) of the Nepal Medical Council Act 1964 and its proviso thereof states that upon voting by two-thirds of the members of the council agreeing to such professional misconduct by the concerned doctor, the name of the doctor is removed from the registration book for a period of two years.

While these cases of malpractice come under the purview of the Nepal Medical Council Act and Rules, the Consumer Protection Act, 1998 also governs services, and medical services also qualify as services under this definition for the purposes of this Act.

Nepal's Consumer Protection Act, 1998 protects a consumer from irregularities concerning the quality of consumer services. Therefore, an aggrieved patient under Section 20 of the act has the recourse of filing a case in the district court within 35 days after the inspection of the inspection officers. As per the act, a complaint for compensation can also be filed with the compensation committee present in each district.

5.1.3 Experience of Malaysia

Presently, the law of tort is resorted to regulate medical negligence litigation in Malaysia. Generally, tortious remedy provides for compensation only when a doctor or any other medical personnel assisting in the treatment of a patient is negligent. Previously, in determining whether a doctor was negligent in diagnosis, treatment and advice, the court had shown a deferential attitude towards medical judgment. This is in contrast to the attitude of the court towards other professions such as engineers and architectures where the court does not hesitate in questioning the appropriateness and reasoning of the standard practice adopted by those professionals. However, this deferential attitude which is encapsulated in the phrase "a doctor knows best" is slowly dissipating.[12]

5.2 Judicial Review and Higher Court's Role in Addressing Medical Negligence in Different Countries

This segment deals with the judicial development in different countries in addressing the issue of medical negligence, regulation of private health care services and above all, the right to proper treatment and health care. Some landmark decisions of the apex courts of different countries will be discussed here in order to analyze how such issues have been tackled by the judiciary in those countries. The experiences and positive judgemnets of the highest courts of law achieved in different countries can be good lesson for Bangladesh in seeking accountability for medical negligence and malpractice of private clinics etc.

5.2.1 Experience of India

In India, a judgment in *Jacob Mathew Vs. State of Punjab* in 2005[13] has made profound impact in a backward direction for appropriate adjudication of medical negligence cases in India. Supreme Court of India defined 'criminal negligence' under this case and held that, to prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do".

---

[12] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3097751, retrieved on 30.03.2013

[13] 6 SCC 1, 2005

A Bench of Mr. Arijit Pasayat and Mr. C.K. Thakkar observed that the words "gross negligence" or "reckless act" did not fall within the definition of Section 304-A IPC, defining death due to an act of negligence or the culpable homicide not amounting to murder. Between Civil and Criminal liability of a doctor causing death of his patient the court has a difficult task of weighing the degree of carelessness and negligence alleged on the part of the doctor. For conviction of a doctor for alleged criminal offence, the standard should be proof of recklessness and deliberate wrong doing with a higher degree of morally blameworthy conduct."

In one of the longest running cases of medical negligence, the National Consumer Disputes Redressal Commission (NCDRC) on 21 October 2011 awarded compensation of Rs. 1.72 crore to the husband of an NRI doctor who had died due to medical negligence while on a social visit to Kolkata in May 1998.[14] This is the highest quantum of compensation in the medico-legal history of India so far. Till now the highest award was of Rs. 1 crore granted to software engineer Prasanta Dhanaka in May 2009. The consumer court asked the Kolkata-based Advanced Medicare and Research Institute (AMRI) Hospital and its three doctors to pay up the compensation for the death of Anuradha Saha, a US-based child psychologist and wife of Dr Kunal Saha. The hospital and the doctors were found guilty of negligence by the Supreme Court in 2009 and the case was referred to the consumer court for the sole purpose of determining quantum of compensation. The NCDRC earlier found no negligence by doctors or AMRI and had dismissed the case in 2006, forcing Saha to approach the apex court. The compensation includes Rs. 41.9 lac each to be paid by AMRI and Dr Sukumar Mukherjee, Rs. 27.93 lac each to be paid by Dr Baidyanath Halder and Dr Balaram Prasad. Another guilty doctor Abani Roychowdhury is dead so the amount due to be paid by him has been deducted from the compensation package. The NCDRC has deducted 10 per cent of the amount for 'contributory negligence' on part of Saha himself as he interfered in the treatment. Saha had sought damages totaling Rs. 77 crore.

Martin D'Souza's Case[15]

This is a case regarding kidney transplant and medicines being administered post-operation wherein there is a dispute about the medicine itself and the

[14] http://indiatoday.intoday.in/story/ncdrc-awards-doctor-rs-1.72-crore-for-wifes-death/1/157099.html, retrieved on 30.03.2013

[15] *Martin F. D'Souza Vs. Mohd. Ishfaq*, AIR 2009 SC 2049

dosage. In 1991, the patient who was suffering from chronic renal failure went to Nanavati Hospital, Mumbai for kidney transplant. He was undergoing haemodialysis twice a week. Later he got his kidney transplant done at Prince Aly Khan Hospital. During his treatment at Nanavati Hospital he did not complain of deafness. At Nanavati Hospital he was prescribed Amikacin of 500 m.g. twice a day for 14 days. Much later, the patient filed a complaint at the National Consumer Dispute Redressal Commission, New Delhi and claimed compensation of Rs. 12 lakhs as his hearing had been affected. He complained that the dosage of Amikacin was excessive and caused hearing loss. The matter finally went to the Supreme Court. Almost all earlier cases pertaining to medical negligence have been discussed by the Supreme Court in the instant case and it was held that the doctor and the hospital were not negligent. Interestingly, this case very strongly defended the position of doctors vis-à-vis the patients.

The court has made an interesting observation:

The law, like medicine, is an inexact science. One cannot predict with certainty an outcome of many cases. It depends on the particular facts and circumstances of the case, and also the personal notions of the Judge concerned who is hearing the case. However, the broad and general legal principles relating to medical negligence need to be understood.

Difficulties in application of Mathew guidelines: The Supreme Court observed that there were difficulties in the application of principles as laid down in Jacob Mathew's case. For instance:

> 1. "The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence is what the law requires." (as per Jacob Mathew's case)

The court observed that it is a matter of individual understanding as to what is reasonable and what is unreasonable. Even experts may disagree on certain issues. They may also disagree on what is a high level of care and what is a low level of care.

> 2. The Jacob Mathew case said that "simple" negligence may result only in civil liability, but "gross" negligence or recklessness may result in criminal liability. Now, what is simple negligence and what is gross negligence may not be so easy to be determined. Experts may not agree on this because the dividing line between the two is quite thin.

Thus, Martin D'Souza's judgment held that it was very difficult or rather impossible to understand, and therefore, define as to what is "reasonable" and what is "simple" and what is "gross". At one place, the court observed:

> "Judges are not experts in medical science, rather they are lay men. This, itself often makes it somewhat difficult for them to decide cases relating to medical negligence."

In short, the Martin D'Souza judgment is like a confession by the judges that in cases of medical negligence, the judges are ill-equipped to make any decision and that too on the finer aspects of "simple" or "gross" negligence.

An interesting order passed by the Supreme Court in this case was a warning given to police officials not to arrest or harass doctors unless the facts clearly come within the parameters laid down in Jacob Mathew's case. Even a threat was given to the policemen that if they did not follow these orders they themselves have to face legal action. Another interesting order was to all the consumer forums – district, state and national – and the criminal courts, that before issuing notice to a doctor or a hospital, against whom the complaint was made, the consumer forum or the criminal court must first refer the matter to a committee of doctors and only when the committee reports of a prima facie case of medical negligence, the notice should be issued.

These two orders were rather surprising because this would have created hurdles in the working of the consumer courts, criminal courts as well as police. As per the law laid down in the Consumer Protection Act, there is no provision for a committee of doctors to first give a prima facie report. It is agreed that in the last 10-15 years there has been a lot of harassment of doctors and hospitals, however it does not mean that the pendulum should swing to the other end. A balance has to be achieved and this is what precisely has been done by another bench of the Supreme Court in Kishan Rao's case in March 2010.

Kishan Rao's case[16]

Kishan Rao got his wife admitted to Nikhil Super Speciality Hospital in Hyderabad as she was suffering from fever and complaining of chill. She was not given any treatment for malaria. Instead she was being treated for typhoid. She did not respond to the treatment. In a very precarious condition, she was shifted to Yashoda hospital where she died due to cardio respiratory

[16] V. Kishan Rao vs. Nikhil Super Speciality Hospital, Supreme Court of India, 8 March 2010, Citation: 2010 (5) SCR 1

arrest and malaria. Kishan Rao filed a case in the District Forum and sought compensation for the negligence of the Nikhil hospital. The hospital delayed filing the case sheet. Finally, the District Forum decided in favour of Kishan Rao. Hospital appealed in the State Commission, which overturned the decision of the District forum on the ground that there was no expert opinion to the effect that the treatment given by the hospital was wrong or the hospital was negligent. National Commission upheld this decision.

Kishan Rao appealed in the Supreme Court, which observed that the case was not complicated which required expert opinion as evidence. It was a simple case of wrong treatment. The patient complained of intermittent fever and chill and was being treated for typhoid instead of malaria. The court held that it was not bound by the earlier decision of the same court in Martin D'Souza's case as that judgment was per incuriam regarding the directions for expert opinion is concerned. The court held that it was not necessary in all cases to seek expert opinion before proceeding with the matter. For simple and obvious cases, the consumer courts were free to proceed without seeking expert opinion and the instant case fell in such a category.

In Martin D'Souza the court did not follow the distinction, as laid down in Jacob Mathew case, regarding criminal prosecution and seeking compensation under Consumer Protection Act. Thus, the guidelines, as laid down in Martin D'Souza, regarding expert opinion before proceeding with any case do not hold good in consumer protection cases and that too which are quite obvious and straightforward. Moreover, the consumer protection law has been enacted to expedite the entire process and the idea of expert opinion at the outset shall defeat the very purpose of the law. Hence the guidelines, as far as expert opinion before issuing notice, are concerned need not be followed. Finally, the Supreme Court allowed the appeal and ordered Nikhil Hospital to pay the amount to Kishan Rao as ordered by the District Forum.

This judgment removed the hurdle created by *D'Souza's Case*. Here, a bench (of equivalent size to the bench of Martin D'Souza's case – both two judges, and one judge common) held that the above mentioned observations of Martin D'Souza's case were *per incurium*. It was held in A.R. Antulay v. R.S. Nayak, reported in (1988) 2 SCC 602 that *per incurium* are those decisions, which are made in ignorance or forgetfulness of some inconsistent statutory provision or of some authority binding on the court concerned, so that in such cases some part of the decision or some step in the reasoning on which it is based, is found, on that count to be demonstrably wrong. The court held that it was not bound by the directions given in D'Souza's case and expert evidence from a committee was not required.

5.2.2 Experience of Malaysia

The Federal Court, the apex court in Malaysia, on 29.12.2006 in its judgment in the case of *Foo Fio Na Vs. Dr. Soo Fook Mun & Another*[17] declared inter alia, that the Bolam Test[18] which has been the basis in determining the standard of care in medical negligence cases in Malaysia since her independence in 1957 is no longer applicable.

The Federal Court in allowing the appeal and upholding the orders of the trial judge in the High Court on quantum held that the Bolam Test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information, of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment.

The Court further held that there is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations. On this basis the *Rogers Vs. Whitaker* (1992) Test[19] would be a more appropriate and viable test of this millennium than the *Bolam* test.

In *Foo Fio Na's* appeal the facts insofar as they were not disputed happened in the following manner. The appellant was a front seat passenger in a motor car that crashed into a tree on the night of 11.07.1982. The car was driven by her boyfriend and there were two other passengers in the back seat. The accident happened near Assunta Hospital where the appellant and her two companions were brought to and where the appellant was subsequently warded for the following injuries.

1. bruises on the lower abdominal wall;
2. bruises on the right breast;
3. bruises on both anterior iliac spine areas;

---

[17] [2007] 1 MLJ 593

[18] Bolam Vs. Friern Hospital management Committee, (1957) 1, 582. Weekly Law Report, Queen's Bench division

[19] Rogers Vs. Whitaker, (1992) 175, 479. Commonwealth Law Report

4. closed dislocation C4 and C5 vertebrae with bilaterally locked facets.

Injury No (4), the most serious of her injuries caused much pain to her neck each time she moved her head. Dr Celine Pereira, the doctor on duty, prescribed the initial treatment by having X-rays taken of her neck and placing a cervical collar around it. Dr Celine Pereira then contacted the orthopaedic surgeon on duty Dr Soo Fook Mun, the first respondent, who was at home at that time and she was advised that the collar should remain and the appellant stabilized by keeping her in bed and placing sandbags on either side of her head to prevent her from moving her head and to reduce the risk of paralysis. This was accordingly done.

Dr. Soo saw the appellant for the first time the following morning and after examining her, prescribed the first treatment by placing her on traction with weights in a further attempt to reduce the dislocated cervical vertebrae. This proved to be unsuccessful and on 14.07.1982, the first respondent performed a manipulation or closed reduction procedure under general anesthetic to unlock the locked facet joint. Despite three attempts, the first respondent failed to reduce the dislocated cervical vertebrae and on 19.07.1982, the first respondent performed the first of two operations to place the dislocated vertebrae into their original positions. This involved an open reduction whereby the nape of the appellant's neck was surgically opened and the dislocated vertebrae moved to their normal positions and secured by bone grafting and the insertion of a loop of wire to stabilize the spinal cord. X-rays were taken after the surgery.

Unfortunately, this procedure too failed as the appellant became paralysed the day after the operation. Suspecting that the paralysis might be due to vascular infarction, ie when blood supply to the spinal cord is interrupted and cut-off, the first respondent prescribed a course of medication to the appellant by the injection of dexamethasone for over four days. When the appellant's condition showed no signs of improvement the first respondent called in a neurosurgeon, Dr. Mohandas, to examine the appellant. Following his examination, Dr Mohandas did a myelogram test on her on 05.08.1982 and he found that the wire loop which was placed to correct the dislocation of C4 and C5 vertebrae during the first operation was pressuring the spinal cord and that was the cause of the total paralysis. As a result of this the first respondent performed a second operation on the appellant on the same day whereby he removed the wire loop. But this treatment too did not remove the paralysis and the appellant continued to be confined to a wheelchair to this very day.

Siti Norma Yaacob FCJ (later CJM) in delivering the judgment of the Federal Court distinguished *Foo Fio Na* from *Bolam* in that:

> "(1) Bolam was a mental patient, and unlike the appellant, who has been described as 'a bright young lady' by the Court of Appeal, it is doubtful whether Bolam was in a position to give any consent to any treatment to be given to him;
>
> (2) had a warning of risk been communicated to him, it is also doubtful whether he was in a position to comprehend the true nature of the risks involved;
>
> (3) the risk of injury in the nature of a fracture to Bolam was one in ten thousand. The same cannot be attributed to the appellant as the risk of paralysis was present and real;
>
> (4) unlike *Bolam's* case there is no conflicting body of medical opinion adduced in the instant appeal to establish whether the appellant should or should not be warned of the risks of paralysis."

The question of law which was posed for the determination of the Federal Court was whether the *Bolam* test in the area of medical negligence should apply in relation to all aspects of medical negligence. The Federal Court answered the question in the negative.

The recent ruling of the Federal Court of Malaysia in *Foo Foo Fio Na Vs. Dr Soo Fook Mun & Another* abandoned the *Bolam* principle in relation to doctor's duty to disclose risks in medical treatment. In this case, Miss Foo Fio Na made an application for leave to appeal to the Federal Court against the decision of the Court of Appeal in *Dr Soo Fook Mun Vs. Foo Fio Na & Another*[20]. The main question for which leave is sought is whether the *Bolam* principle in the area of medical negligence should apply in relation to all aspects of medical negligence. The Federal Court held that the question posed and the decision to be made would be to public advantage. In this regard, the Federal Court found it necessary to reconsider whether the *Bolam* principle should apply to all aspects of medical negligence, particularly, in determining the standard of care of medical practitioners in providing advice to patients on the inherent or material risks of the proposed treatment. After four years and seven months, the Federal Court have made the long awaiting decision by deciding that the *Bolam* principle is no longer to be applied to doctor's duty to disclose risks.

---

[20] [2001] 2 CLJ 457

The test enunciated in *Rogers v Whitaker*[21] would be "a more appropriate and available test of this millennium."[22] The court opined that "the *Bolam* test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment."[23] The court was of the view that "there is a need for members of the medical profession to stand up to the wrong doings, if any, as is the case of professionals in other professions. In so doing, people involved in medical negligence cases would be able to obtain better professional advice and that the courts would be appraised with evidence that would assist them in their deliberations."[24] The decision of the Federal Court has obviously put a potentially onerous task for the medical practitioners, but is nevertheless one, which the law considers as necessary.

[21] Supra

[22] [2007] 1 MLJ 593, at paragraph 69

[23] Ibid, at paragraph 36

[24] Ibid, at paragraph 69

Part VI

Seeking Accountability in Medical Services through PIL

Public Interest Litigation (PIL) has become a recognized means for protecting rights of the people. In Bangladesh PILs are filed in the High Court Division of the Supreme Court under Article 102 of the Constitution. Like other parts of the South Asia, PIL is seen as an important tool to ensure accountability of the State machineries in Bangladesh. As Hans Dembowski (2001:3) observes:

> "Public interest litigation (in which agents of civil society sue the government) does permit some access to the wielders of state power and, accordingly, a minimum level of scrutiny of their doings. Courtrooms can thus become the location of a rudimentary 'public sphere', defined here as the arena in which civil society and state interact in a rational, critical and rule-bound rather than merely hierarchical discourse."

Since, the early 1990s PILs have generated a new flow of activism, particularly by making the government agencies answerable for their actions or inactions contrary to the constitution and legal provisions. Despite different limitations and difficulties, PIL has accorded some leverage for the people and civil society actors in Bangladesh, to address the indifference and irresponsibility of the State agencies in discharging their duties to protect the constitutionally guaranteed rights of the people. In this part the experience of Bangladesh on PILs relating to medical services would be discussed first; then the achievements of PIL or constitutional cases on similar subject matter in other national jurisdictions will be assessed. The last segment will attempt to identify the difficulties and challenges for PIL in seeking accountability of medical practitioners, service providers and overseers of medical and health administration.

6.1 Bangladesh's Experience and Achievement

This segment will discuss two PILs on medical issues. In both the PILs ASK is the petitioner. The first one is relating to quality control and monitoring of private clinics etc., the second one is about patient's right of proper and uninterrupted treatment.

Medical Negligence-Private Clinics Case[25]

[25] Ain o Salish Kendra Vs. Government and others, Writ Petition No. 624 of 2006

On the pretext of State's limitations and lack of resources to ensure medical services for all, the country experienced a mushrooming of private clinics, medical centres and laboratories all over the country for the last couple of decades. The government apparently failed to ensure quality control and proper service of these private clinics. The Director General of Health Directorate has been responsible for monitoring of private clinics and laboratories, under the Medical Practice and Private Clinics and Laboratories (Regulations) Ordinance, 1982. The powers of the Director General and relevant provisions of the Ordinance have already been discussed in Part III. In spite of that an utter anarchy continued in private medical sector. Private clinics and medical centres had been observed to operate without license and legally required facilities. In addition to that there were so called clinics and medical centres with no registered or recognized medical practitioners and thus, carrying on an out and out fraudulent business in the name of treatment. According to ASK's documentation from different newspaper reports from 19.02.2004 to 27.08.2005 at least 65 people died due to fraudulent practices or gross negligence of private clinics (Annexure-L to the writ petition).

The writ petition (PIL) also referred to a number of reports published in different newspapers that reveal the horrific situation of private clinics and medical centres all over the country. In support of the statements and published news reports, the petition also annexed reports (Annexures-E,G1) of some fact finding investigations which ASK's Investigation Unit conducted on different reported incidents of medical negligence. Upon investigation it was found that most of the private clinics are not properly equipped and there is no authorized doctor and nurses and they are conducting major operations without essential arrangements.

The petitioner impugned the failure of concerned authorities to perform their respective functions and legal duties to ensure proper monitoring of the private clinics under the Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982. On admission, the Court issued a *Rule Nisi* upon the Government on 29.01.2006 to show cause as to why their failure to ensure compliance with the Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982 in particular, Sections 8, 9, and 11 should not be declared illegal and without lawful authority as violative of fundamental rights under Articles 27, 31, 32 of the Constitution and as to why they should not be directed to discharge their legal duties to ensure compliance with the Ordinance by taking appropriate steps. Pending hearing of the *Rule Nisi*, the Court directed the Director General of Health to ensure compliance of the above-mentioned Ordinance. The case is now pending for final hearing.

Intern Doctors' Strike Case[26]

This PIL asserted the rights of the patients to have proper and uninterrupted treatment. This time it was different public and private hospitals that are also engaged in imparting medical education. Rampant strike by the intern doctors had been observed in different hospitals, denying treatment even to the already admitted, under-treatment and emergency patients. On many occasions, such strikes led to death of patients[27]. Such a ruthless mode of protest and negligent attitude to the professional duty, clearly constitutes severe misconduct, violates the professional oath and manifestly contravenes the very spirit of medical profession. Almost in all cases of such strikes, the Government and its concerned authorities also failed to take appropriate and prompt steps to immediately resolve the issues. Such strikes became a common and recurrent phenomenon in the hospitals, causing immense suffering to the people, especially the under-treatment patients and their relatives.

The State and its authorities constantly failed to take prompt and effective actions to investigate the complaints of misconduct of intern doctors, in the form of abstinence from work or strike, which causes violation of right to health care and access to medical support, to some extent even right to life. This PIL challenged the indifference of the concerned authorities and their failure to take appropriate actions in this regard. The Court issued a *Rule Nisi* on 30.05.2010, calling upon the respondents to show cause as to why their failure to take any action, in particular pursuant to the Bangladesh Medical and Dental Council Act and the Code of Conduct for the intern doctors framed by the Ministry of Health and Family Affairs, to investigate the allegations of strikes called by the intern doctors in different hospitals across the country resulting in death of patients and deprivation of citizens from access to emergency healthcare, should not be declared illegal, without lawful authority and unconstitutional; being in violation of the fundamental right to life including the right to health and as to why Bangladesh Medical and Dental Council and its Chairman should not be directed to comply with their duties under the Bangladesh Medical and Dental Council Act, 1980 to take appropriate action against those found to have participated in such

[26] Ain o Salish Kendra Vs. Bangladesh and others, Writ Petition No. 4319 of 2010

[27] In 2008, a three-day long strike of intern doctors at MAG Osmani Medical College Hospital, Sylhet resulted in death of total 34 patients (*Sangbad,* 08.04.2008 and 09.04.2008). This is only one instance among many other similar incidents of strike or agitation of intern doctors and consequent death of patients.

strikes in violation of the Code of Medical Ethics and the said Code of Conduct of 1998, and why the respondents should not be directed to submit reports on the steps taken by them to adopt and implement the said Code of Conduct of 1998 to date, and to investigate the allegations of misconduct by the intern doctors, as detailed in the Annexure to the petition; to take actions against those responsible, pursuant to the Bangladesh Medical and Dental Council Act 1980 and the said Code of Conduct of 1998. The case is now pending.

6.2 Achievements in Other National Jurisdictions

In this section the achievements of PIL or similar constitutional cases in other national jurisdictions on right to health, treatment and other aspects of medical services will be discussed. In this regard, experience of India and South Africa seem to offer a good lesson for Bangladesh. The first case cited here is an Indian PIL on right to access to health care and treatment. The second one is a South African development, showing the potential of PIL in ensuring health rights.

Paschim Banga Khet Mazdoor Samity and others Vs. State of West Bengal and another[28]

The petitioner filed this writ petition impugning the indifferent and callous attitude on the part of the medical authorities at the various State run hospitals in Calcutta in providing treatment for the serious injuries. The fact of the case was that Hakim Seikh [petitioner No. 2], who is a member of Paschim Banga Khet Mazdoor Samity [petitioner No. 1], an organization of agricultural labourers, fell off a train at Mathurapur Station in West Bengal at about 7.45 P.M. on July 8, 1992. He suffered serious head injuries and brain haemorrhage. He was taken to the Primary Health Centre at Mathurapur. Since necessary facilities for treatment were not available at the Primary Health Centre, the medical officer in charge of the Centre referred him to the Diamond Harbour Sub-Divisional Hospital or any other State hospital for better treatment. Hakim Seikh was taken to N.R.S. Medical College Hospital near Sealdah Railway Station, Calcutta at about 11.45 P.M. on July 8, 1992. The Emergency Medical Officer in the said Hospital, after examining him and after taking two X-ray prints of his skull recommended immediate admission for further treatment. But Hakim Seikh could not be admitted in the said hospital as no vacant bed was available in the Surgical Emergency ward and the regular Surgery Ward was also full. He was thereafter taken to Calcutta Medical College Hospital at

[28] 1996 SCC (4) 37

about 12.20 A.M. on July 9, 1992 but there also he was not admitted on the ground that no vacant bed was available. He was then taken to Shambhu Nath Pandit Hospital at about 1.00 A.M. on July 9, 1992. He was not admitted in that hospital and referred to a teaching hospital in the ENT, Neuro-Surgeon Department on the ground that the hospital has no ENT Emergency or Neuro-Emergency Department. At about 2.00 A.M. on July 9, 1992 he was taken to the Calcutta National Medical College Hospital but there also he was not admitted on account of non-availability of bed. At about 8.00 A.M. on July 9, 1992 he was taken to the Bangur Institute of Neurology but on seeing the CT Scan (which was got done at a private hospital on payment of Rs.1310/-) it was found that there was haemorrhage condition in the frontal region of the head and that it was an emergency case which could not be handled in the said Institute. At about 10.00 A.m. on July 9, 1992 he was taken to SSKM Hospital but there also he was not admitted on the ground that the hospital has no facility of neuro-surgery. Ultimately he was admitted in Calcutta Medical Research Institute, a private hospital, where he received treatment as an indoor patient from July 9, 1992 to July 22, 1992 and he had incurred expenditure of approximately Rs. 17,000/- in his treatment. Being aggrieved by such indifferent and callous attitude of the medical authorities in different hospitals he and the Samity filed this PIL and also claimed compensation from the government.

The Court recognized the right to have medical care as a right to life and also recognized State's obligation in providing emergency medical services to the citizens. S C Agarwal J held:

> "Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21."

Referring to Rudal Sah Vs. State of Bihar, 1983 (3) SCR 508; Nilabati Behara Vs. State of Orissa. 1993 (2) SCC 746: Consumer Education and Research Centre Vs. Union of India, 1995 (3) SCC 42 the Court decided in favour of compensation and argued:

> "Since the said denial of the right of Hakim Seikh guaranteed under Article 21 was by officers of the State in hospitals run by the State the State cannot avoid its responsibility for such denial of the constitutional right of Hakim Seikh. In respect of deprivation

> of the constitutional rights guaranteed under Part III of the Constitution the position is well settled that adequate compensation can be awarded by the court for such violation by way of redress in proceedings under Articles 32 and 226 of the Constitution."

During pendency of the writ petition in the Court, the State Government decided to make a complete and thorough investigation of the incident and take suitable departmental action against the persons responsible for the same and to take suitable remedial measures in order to prevent recurrence of similar incidents. The State Government appointed an Enquiry Committee headed by Shri Justice Lilamoy Ghose, a retired Judge of the Calcutta High Court. The Committee came up with specific recommendations which have been accepted by the State Government. Based on the recommendations of the Committee and the Court's overall observation on the matter, it ended up with the following directives:

1. Adequate facilities are available at the Primary Health Centres where the patient can be given immediate primary treatment so as to stabilize his condition;

2. Hospitals at the district level and Sub-Division level are upgraded so that serious case can be treated there;

3. Facilities for giving specialist treatment are increased and are available at the hospitals at District level and Sub-Division level having regard to the growing needs;

4. In order to ensure availability of bed in an emergency at State level hospitals there is a centralized communication system so that the patient can be sent immediately to the hospital where bed is available in respect of the treatment which is required;

5. Proper arrangement of ambulance is made for transport of a patient from the Primary Health Centre to the District hospital or Sub-Division hospital and from the District hospital or Sub Division hospital to the State hospital;

6. The ambulance is adequately provided with necessary equipment and medical personnel;

7. The Health Centres and the hospitals and the medical personnel attached to these Centres and hospitals are geared to deal with larger number of patients needing emergency treatment on

account of higher risk of accidents on certain occasions and in certain seasons.

Thiagraj Soobramoney Vs. Minster of Health (Kwazulu-Natal)[29]

In this South African case, although the appellant did not get the desired relief; it is very important to discuss certain aspects of the judgement, to analyze the approach of the Constitutional Court of South Africa, in dealing with more intricate issues of right to health and treatment. The appellant, a 41 year old unemployed man, was a diabetic who had been suffering from ischaemic heart disease and cerebro-vascular disease which caused him to have a stroke during 1996. In 1996 his kidneys also failed. His condition was irreversible and by that time he was in the final stages of chronic renal failure. His life could be prolonged by means of regular renal dialysis. He had sought such treatment from the renal unit of the Addington state hospital in Durban. The hospital could, however, only provide dialysis treatment to a limited number of patients. The renal unit had 20 dialysis machines available to it, and some of these machines were in poor condition. Each treatment took four hours and a further two hours had to be allowed for the cleaning of a machine, before it can be used again for other treatment. Because of the limited facilities that were available for kidney dialysis the hospital had been unable to provide the appellant with the treatment he had requested.

The reasons given by the hospital for this were set out in the respondent's answering affidavit deposed to by Doctor Saraladevi Naicker, a specialist physician and nephrologist in the field of renal medicine who had worked at Addington Hospital for 18 years and who was at that time the President of the South African Renal Society. In her affidavit Dr Naicker said that Addington Hospital did not have enough resources to provide dialysis treatment for all patients suffering from chronic renal failure. Additional dialysis machines and more trained nursing staff were required to enable it to do this, but the hospital budget did not make provision for such expenditure. The hospital would like to have its budget increased but it had been told by the provincial health department that funds were not available for this purpose. Because of the shortage of resources the hospital used to follow a set policy in regard to the use of the dialysis resources. Only patients who suffer from acute renal failure, which can be treated and remedied by renal dialysis, were given automatic access to renal dialysis at the hospital. Those patients who, like the appellant, suffer from chronic renal failure which is irreversible were not admitted automatically to the renal programme. A set of guidelines had

[29] Case CCT 32/97, Constitutional Court of South Africa, decided on 27.11.1997

been drawn up and adopted to determine which applicants who have chronic renal failure will be given dialysis treatment. According to the guidelines the primary requirement for admission of such persons to the dialysis programme was that the patient must be eligible for a kidney transplant. A patient who is eligible for a transplant would be provided with dialysis treatment until an organ donor is found and a kidney transplant has been completed. The guidelines provided that an applicant is not eligible for a transplant unless he or she is "[f]ree of significant vascular or cardiac disease." The medical criteria set out in the guidelines also provide that an applicant must be

> "Free of significant disease elsewhere e.g. ischaemic heart disease, cerebro-vascular disease, peripheral vascular disease, chronic liver disease, chronic lung disease."

The appellant suffered from ischaemic heart disease and cerebro-vascular disease and he was, therefore, not eligible for a kidney transplant.

The appellant made arrangements to receive dialysis treatment from private hospitals and doctors, but his finances had been depleted and he averred that he was no longer able to afford such treatment. In July 1997 he made an urgent application to the Durban and Coast Local Division of the High Court for an order directing the Addington Hospital to provide him with ongoing dialysis treatment and interdicting the Respondent from refusing him admission to the renal unit of the hospital. The appellant claimed that in terms of the 1996 Constitution the Addington Hospital is obliged to make dialysis treatment available to him. The respondent opposed the application. The matter came before Combrinck J who dismissed the application.[30] The appellant applied to the High Court for a certificate in terms of rule 18(e) of the Constitutional Court Rules. The certificate was granted and he applied to this Court in terms of Rule 18 for leave to appeal against the judgment of the High Court. The application for leave to appeal was set down for hearing as a matter of urgency. The respondent did not oppose the application and correctly acknowledged that the matter raised issues of importance on which a decision on the merits of the appeal should be given by this Court. The matter was dealt with on this basis, and counsels were required to deal only with the merits of the appeal, it being accepted by the parties and this Court that the appeal should be heard and decided.

---

[30] *Thiagraj Soobramoney v Minister of Health: Province of KwaZulu-Natal* D&CLD 5846/97, 21 August 1997, unreported.

The appellant based his claim on section 27(3) of the 1996 Constitution which provides:

> "No one may be refused emergency medical treatment"

and section 11 which stipulates:

> "Everyone has the right to life."

After an elaborate discussion of the issues, in which the *Khet Mazdoor* case of India was also cited, the Court dismissed the appeal, while recognizing the constitutional guarantee of right to health care "within the available resource". While facing the real difficulty of lack of resources the Court with utmost precision, came up with the reasoning of prioritizing primary obligations to provide health care services to everyone within the available resources of the State; without entailing a negative condition for access to health care rights subject to resources or taking the easy route of technical interpretation which could have a squeezing impact on the progressive constitutional guarantee in favour of right to health care services. Chaskalson P, J (para:19) held:

> "In our Constitution the right to medical treatment does not have to be inferred from the nature of the state established by the Constitution or from the right to life which it guarantees. It is dealt with directly in section 27. If section 27(3) were to be construed in accordance with the appellant's contention it would make it substantially more difficult for the state to fulfill its primary obligations under sections 27(1) and (2) to provide health care services to "everyone" within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening. In my view much clearer language than that used in section 27(3) would be required to justify such a conclusion."

Appreciating the Indian approach in *Khet Mazdoor* case the Court, with reasons declined to accept the factual similarity of the two cases, and also clarified the distinct position of South African Constitution in recognizing ESC rights (para:20):

> "Section 27(3) itself is couched in negative terms – it is a right not to be refused emergency treatment. The purpose of the right seems to be to ensure that treatment be given in an emergency,

> and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate medical attention, such as the injured person in *Paschim Banga Khet Mazdoor Samity v State of West Bengal*, should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment.[31] What the section requires is that remedial treatment that is necessary and available be given immediately to avert that harm."

This is a glaring example as to how a constitutional court can progressively address the intricate issues of right to health care and tackle the "availability of resource" issue without limiting the broader and prospective aspects of the constitutional guarantee in question.

6.3 Limitations and Challenges in Bangladesh

In the context of Bangladesh, whether it is about medical services or any other issue, there are some limitations and challenges in seeking accountability through PIL, which are apparent and well-known to the activists, lawyers, and organizations involved with PILs. In addition to that, as because the very subject matter itself involves a specialized field, some special limitations and challenges can also come into play. Altogether, the limitations and challenges can be expressed as follows:

- Lack of resources to adequately address the diverse and vast aspects of medical and health care services such as problems existing in monitoring of manufacturing and distribution of medicines, operation of private clinics, management of public and private hospitals, private diagnosis centres and laboratories, medical education, fraudulent practices, malpractice and actual cases of medical negligence including incidents involving delicate and complicated questions of medical jurisprudence.

- A very few number of NGOs have been involved with this issue.

---

[31] "We have only recently emerged from a system of government in which the provision of health services depended on race. On occasions seriously injured persons were refused access to ambulance services or admission to the nearest or best equipped hospital on racial grounds" (as cited in the Judgement)

- Lack of expertise in medical and health care issues and their specialized aspects on the part of organizations, individuals and lawyers dealing with medical negligence and similar issues.

- Inconsistency in follow up with a constant momentum. Particularly the same NGOs are involved in various other issues; on emergence of a more urgent issue according to their organizational priority, they become busy with that other issue, and that one of medical negligence remain no more of importance until a subsequent "breaking news".

- Absence of stable and expanded networking including individual activists, experts and NGOs.

- A strong sense of apprehension prevailing, particularly among the medical practitioners that any kind of litigation involving medical profession, would instigate unnecessary harassment and hinder their professional performance.

- Lack of requisite knowledge among the Judges of the Supreme Court to appropriately deal with the issues like medical negligence.

- Slow progress and lack log of cases. The two PILs filed by ASK, which have been discussed in this report, are still pending, for 5 years and 3 years respectively; although the subject matters or list of respondents who are required to reply by filing affidavit in opposition, do not justify such long pendency.

- Non-cooperation of the Government (administration) in disposal of PILs and Court's failure to ensure Government's response within a reasonable time.

- The greatest challenge would be the implementation, even if, any positive outcome is achieved through PILs. It has been observed in case of many other PILs of ASK that the orders and directives of the Court given in a PIL judgement are not being properly complied with or totally ignored by the authorities concerned.

Part VII

Recommendations

Based on the assessment of different aspects of laws and policies in the preceding parts, some recommendations for legal advocacy are made in this part. These recommendations concern policy-level interventions, legal reform and initiatives for bringing a change in the existing practices. Bangladesh Law Commission has also made a set of proposals which have been discussed in 3.5. The Commission's suggestion and the assessment of this report come to the concurrent conclusion regarding necessity of a fresh and specific law on medical negligence. These, recommendations can render better result if implemented in time bound logical framework.

7.1 Recommendations for Policy Advocacy

1. Develop a time bound plan of action for policy advocacy; upon identifying and prioritizing the sectors of medical and health care services where there is a need for specific policy guidelines in order to ensure right to health care and proper treatment.

2. Lobby with the Government to expedite specific legislation on medical negligence and implementation of strategic plan of the NHP, 2011.

3. International advocacy and networking with a view to highlight the want of accountability in the medical sector of Bangladesh and motivate the international pressure groups to press the Government of Bangladesh to take measures on the issue.

4. Liaison with the Government agencies in order to identify the lacuna in the policies that are contributing to or aggravating the difficulties with monitoring of medical services.

5. Form specific proposals for policy reform and negotiate with the Government.

6. Advocacy for increase of national health budget, greater allocation for public hospitals and adequate supply of medical equipments, medicines and other resources in the public hospitals.

7. Policy advocacy with a view to ensure promotion of alternative systems of medicine; such as Unani and Ayurvedic medicine.

7.2 Recommendations for Legal and Institutional Reform

1. Liaison with the Law Commission and provide feedback or submit draft of a proposed law on medical negligence. In addition to providing a specific definition of medical negligence, the law will make comprehensive provisions for victims to get remedy and set a sound procedure to that end.

2. To undertake advocacy initiatives towards establishing a permanent tribunal under the BMDC, if necessary by amending the Bangladesh Medical and Dental Council Act, 2010, to adjudicate the allegations of negligence, malpractice and misconduct against registered medical practitioners and medical assistants. Independent of any civil and criminal proceeding, the tribunal can be empowered to take disciplinary actions including cancellation of registration under the Act. The tribunal may also be authorized to investigate, take actions and/or forward formal complaint to the law enforcement agency or competent judicial authority, as applicable, against persons carrying on medical practice with false identity or by fraudulent or unlawful means.

3. Devising specific suggestions to ensure transparency of the BMDC as a regulatory body of medical profession.

4. Liaison with the BMDC and other concerned authorities to revise the curricula of medical education and include special courses/subjects on medical negligence with greater emphasis.

5. To negotiate with the Government and provide necessary consultation in order to ensure effectiveness of the directorate of health in monitoring of private clinics, laboratories etc.

6. Liaison with the Judicial Administration Training Institute (JATI) to include special modules on medical negligence and its civil and criminal remedies.

7. To take special measures and strengthen GO-NGO cooperation for capacity building of the law enforcement agencies in investigating offences of medical negligence.

7.3 Recommendations as to Improvement of Existing Practice and Awareness Building

1. Arrange training of the young lawyers to develop their skill and expertise in preparing and conducting civil and criminal cases on medical negligence.

2. Provide legal aid to the victims of medical negligence and encourage litigation.

3. Take legal actions and follow up cases of medical negligence.

4. To ensure citizen's charter to be displayed in a conspicuous place, in all public and private medical and health care centres.

5. Take initiatives to ensure proper documentation and preservation of medical data in every medical centre, private clinics and private or public hospitals; and also to ensure lawful access of the people to the preserved medical data.

6. To initiate public debates on different aspects of health care rights and medical negligence.

7. To introduce awareness programmes to raise awareness of the people about their right to health and proper treatment.

8. Launch awareness programmes to sensitize the medical practitioners regarding the legal consequences of negligence, malpractice and misconduct, and the sufferings of the patients as a result of that.

9. Strengthen the networking of different NGOs, individuals and experts working on medical negligence and health care issues and develop a combined plan of action.

10. Arrange for publication and dissemination of positive judgements and rulings of the Hon'ble Court, obtained in PILs relating to right to health care, medical negligence and/or professional misconduct.

Part VIII

Conclusion

Medical negligence and lack of accountability in the entire health care administration have led to an unbearable condition both in public and private health care sector of Bangladesh. Limited resources, shortage of necessary equipments and medicines and an abnormally disproportionate ratio of doctors and nurses against patients- all these are reality in the context of medical services in Bangladesh. Nevertheless, with utmost respect to the contribution of the medical professionals who are delivering services in such an adverse condition, it must be clarified that such a reality or scarcity cannot be accepted as a justification for negligence, misconduct or unscrupulous activities. It is all the more important to state that all these vices are ultimately found to be interconnected. Therefore, the vicious chain has to be severed from a certain point, and that is accountability. A greater sense of accountability, will not only encourage public trust upon medical profession, but also substantially improve the overall condition of health care services in the country. Instead of replaying the stereotyped plea of limited resource, the government should also give a considerate thought to the outflow of remittance per year due to citizens' opting for foreign treatment. Again, there is no doubt that the government has to play the central role in order to bring a change. But, at the same time, it is also essential that the civil society attributes including the NGOs, have to trigger the process and continue interacting with the government and each other through to the transformation.