Tuijin Jishu/Journal of Propulsion Technology
ISSN: 1001-4055
Vol. 44 No. 5 (2023)

Right to life & Denial of Medical Emergency Treatment and its Subsequent Liability*

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Abstract- No Indian law, whether it be coded or uncoded, specifically mentions emergency medical care or the liability that goes along with it[1] What we can only infer from this is that when a doctor refuses to provide a medically essential treatment for irrational reasons, they are not directly liable and cannot be sued. There is no clear-cut basic standard of care that medical practitioners must adhere to in urgent and critical situations; instead, this depends entirely on the doctors' will. This article's main goal is to help readers understand how doctors can be held accountable when a patient is denied emergency care for careless reasons, such as the patient's inability to pay, the doctor's own interests, the need to follow protocol, etc. These reasons stand beyond the realm of medical reasonability and are unenforced by sound justifications like lack of expertise or equipment, or space. These explanations go beyond what is reasonable from a medical standpoint and are not supported by valid arguments like a lack of knowledge, resources, or available space.

Keywords – Medical Emergency care, Emergency department, Medical negligence, Medical Professional, Treatment

Introduction

'Emergency case' can be defined as a treatment by a medical professional so required that its non-performance can be hazardous to the patient's life. According to the American College of Emergency Physicians (ACEP), an emergency is defined as any condition perceived by the prudent layperson, or someone on his or her behalf, as requiring immediate medical or surgical evaluation and treatment.[2] In such situations, the inaccessibility of medical facilities becomes unconstitutional if it is corrupted by the greed and self-interest of medical professionals. In the Indian healthcare system, the lack of public access to healthcare and its resultant impact on quality are clearly seen.[3] It is normal and recognised for there to be a wealth gap, which has an effect on the calibre of medical personnel, the course of therapy, and the medications utilised. But when this socioeconomic gap comes down to a question of life and death, things go horribly wrong. The continual obsession of private hospitals with "pay first" and completing medico-legal requirements in the majority of medical cases provides a barrier to healthcare for the underprivileged and uninformed. Although the idea of "medical care first, legal formalities later" was correctly established by the landmark decision Pt. Paramanand Katara v. The Union of India3, its appropriate, direct, and coordinated application needs to be secured by comprehensive legislation. It is vital to comprehend that there is no second chance to save human life. In certain situations, the previous state of affairs cannot be restored.

[1] Common Cause (A Regd. Society) v. Union of India and Another, 2014 SCC 5 338.

[2] EMERGENCYMEDICINE.IN, https://www.emergencymedicine.in/current/articles.php?article_id=9 (last visited May 24, 2023).

[3] Pt. Paramanand Katara v. The Union of India, 1989 AIR 2039.

According to the current situation in India, "with more than 150,000 traffic-related deaths, 98.5% of "ambulance runs" transporting dead bodies, 90% of ambulances lacking equipment or oxygen, 95% of ambulances with untrained personnel, the majority of ED (Emergency Department) doctors lacking formal training in EMS (Emergency medical services), misuse of government ambulances, and 30% mortality due to delay in emergency care, India portrays a mirror image of the United States of the 1960s.'"[4] Additionally, the number of fatalities from traffic accidents rose by 7% in the first five months of 2022, underscoring the urgent need to improve post-crash (medical) treatment.[5] After a bike accident, a little kid was hurt, but the medical institution refused to treat him since the party responsible for the accident couldn't pay. This ultimately drove the boy to the edge of death.[6] a physician is not required to treat everyone who seeks out his services, save in cases of emergency, it was ruled later. In order to follow through on the application of the same, the Doctor may be held accountable for denying emergency instances.

The Responsibility

When it comes to this issue, the Indian judicial system has led the way. It has established precedent in terms of medical negligence's "duty to care" or "standard form of care" concepts. Medical malpractice is any carelessness committed by a medical professional when that professional either has the necessary training for the treatment or when that treatment is delivered carelessly, hastily, or incorrectly and falls below the standard of reasonable competence.[7] Any medical expert must therefore provide reasonable professional care that falls within the norm for their field. It's not necessary to have the best or worse quality. This implies that all doctors must accept emergency cases because to refuse them would be unethical and go beyond what a doctor should reasonably be expected to do. 'Beyond the field of performance or skill' of that masterly should be the only defence that can be used to refute any emergency situation.

'Every Doctor whether at a Government Hospital or otherwise has the professional obligation to extend his service with due expertise for protecting life. No law or state action can intervene to avoid/delay the discharge of this paramount obligation cast upon members of the medical profession. The obligation being total, absolute and paramount.'[8]

The 'Golden Hour' is another name for the essential time frame that exists inside this severe situation. This time period marks the window of opportunity when receiving medical care can affect a patient's chances of survival. It encompasses the first hour following an injury, during which time bystander and medical assistance might improve the likelihood of survival. This cardinal period may range from a few essential minutes of survival to a few hours, depending on the circumstances. This idea serves as an example of the requirement for "immediate treatment in emergency cases."

[4] Government of India, NITI Aayog, *Report on Country-level assessment of emergency and injury care at secondary, tertiary level centres and district hospitals in India,* (May 24, 2023, 2:23am), https://pib.gov.in/PressReleasePage.aspx?PRID=1780041.
[5] World Bank, *Traffic crash injuries and disabilities: The burden on Indian society*, (May 24, 2023, 2:23am), https://www.worldbank.org/en/country/india/publication/traffic-crash-injuries-and-disabilities-the-burden-on-indian- society.
[6] Pravat Kumar Mukherjee v. Ruby General Hospital II, (2005) CPJ 35 (NC).
[7] Bolam v. Friern Hospital Management Committee, [1957] 1 WLR 582.
[8] Paschim Banga Khet Mazdoor Samiti v. State of West Bengal, (1996) AIR SC 2426.

Moreover, the essential freedom protected by Article 21[9], which is, Right to life, has also been interpreted graciously by the Apex Court. It envisages the 'Right to Health' as an integral part.[10]

It obligates the state to preserve life. In this regard, the Supreme Court ruled that denial of emergency treatment is a violation of the Right to life guaranteed under Article 21 of the Constitution.[1112] All those limbs and capacities through which life is enjoyed12, which should in the main include access to high-quality healthcare services, are included in the idea of living beyond basic animal existence and the restriction against its deprivation.

The outlined standard of care for medical professionals can also be derived from Section 1.8[13] of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, which renders contracts of 'no payment no cure' unethical. Sections 2.1.1[14] and 2.4[15] state that No doctor may unilaterally refuse to treat a patient in an emergency, and he or she "should, however, respond to any request for his assistance in an emergency," according to the rules. According to the Clinical Establishment Act of 2010, medical facilities have a responsibility to take all reasonable emergency response procedures.[16]

Eventually, a correlation between medical services and 'services' within the Consumer Protection Act, 1986 under section 2 (o)[17] has been established.[18] But, it requires adherence to two pre- requisites including:

a) Service(s) should not be free of cost

b) Service(s) should not be rendered through a contract of personal service

Herewith, at first sight, many emergency cases which involve non-payment might fall within the first condition. Still, analyzing the same, we must understand that 'consumer' under section 2 (d)[19] of the parent act includes payments that are partly done or initiated with a promise for further performance. Furthermore, the 'free services' should be free to one and all which, is not the case here.[20] The likelihood that the patient or their family may file a lawsuit against the medical provider for any carelessness or failure to follow the accepted procedure will consequently rise.

However, these liabilities fall short of expectations. Furthermore, severe deterrent for medical facilities and specialists is required by direct liabilities. The aforementioned obligations can be purchased, but given the seriousness of the situation, particularly in India, severe and comprehensive legislation is needed.

What's lacking?

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[9] INDIA CONST. art. 21.

[10] Bandhua Mukti Morcha v. Union of India, (1997) 10 SCC 549.

[11] *Id.* at 8.

[12] Kharak Singh v. State of Uttar Pradesh and Ors., 1963 AIR 1295.

[13] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Indian Medical Council Act, 1956, § 1.8, No. 102, Acts of Parliament, 1956 (India).

[14] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Indian Medical Council Act, 1956, § 2.1.1, No. 102, Acts of Parliament, 1956 (India).

[15] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Indian Medical Council Act, 1956, § 2.4, No. 102, Acts of Parliament, 1956 (India).

[16] Clinical Establishment Act, 2010, § 12, No. 23, Acts of Parliament, 2010 (India).

[17] Consumer Protection Act, 1986, § 2 cl.o, No. 68, Acts of Parliament, 1986 (India).

[18] Indian Medical Association v. VP Shantha, 1996 AIR 550.

[19] Consumer Protection Act, 1986, § 2 cl.d, No. 68, Acts of Parliament, 1986 (India).

[20] *Id.* at 18.

Emergency situations are an exception to this rule. Liability must arise when a doctor intentionally selects their patient and their course of treatment. The issue at hand is whether a doctor can be held accountable for the patients he does not willingly select. The only reason is for the professional obligation to care that he has, which is to save lives. This question's response requires clarity.

After the patient receives any medical care, liability can shortly follow. It is necessary to properly clarify the professional's requirements and legal framework in emergency situations while still requiring that they adhere to the abstractions of reasonableness and carefulness. The current procedures fall short of offering a complete legal framework for culpability in emergency situations In another instance, the patient was denied emergency care and died as a result of the doctor's inappropriate behavior. Here, the doctor argued in defence that the patient had not given consent and that since the accident would fall under medico-legal law, only a government institution should handle it. However, this argument was rejected, arguing that as this agreement is primarily intended to limit the doctor's culpability for any potential issues in the future, it cannot be deemed to be as crucial as a patient's life.[21] Numerous incidents, including the one described above, continue to happen in society. Despite the fact that there are currently available measures, there are several factors at play. The most obvious is the lack of any regulation that specifically and fully addresses medical emergency situations. The urgent requirement is for legislation that protects India against significant emergency instances and their eventual liabilities. The differentiation between criminal and civil liability in terms of the seriousness of the act

committed must also be defined and ingrained in the minds of medical professionals to restrain future mishaps. The states and the centre may develop a state-wide EMS Policy as the first step towards a comprehensive legal framework, then develop and operationalize guidelines and procedures for putting that policy into practise. At a later time, the need for an Act may be assessed and the necessary legislation may be enacted.[2223] It is necessary to make some crucial elements, such as screening and stabilising, essential. Every person who seeks emergency medical care should undergo a screening that is unaffected by any outside factors. The proper course of action, such as stabilising, transferring, or treating, should then come next.

Second, the public should be made aware of the public-private division in hospital services and the corresponding rights. In the case of Shishir Rajan Saha v. The State of Tripura23, a doctor prioritised treating his wealthy and personal patients over saving a patient's life. Every person's legal rights in the public and private healthcare systems should be known. Prioritising health over wealth should be a requirement for all private hospitals. In light of this, private hospitals shouldn't abandon their responsibility of care before an unfixable issue has arisen. In recent years, it has become customary for private hospitals to refer the poor and needy to public healthcare facilities out of concern for payment defaults. However, the average individual nowadays finds it much more acceptable to pay for healthcare at these private institutions than to put up with the pervasive unprofessionalism in many public health care delivery systems. This has led to a type of anarchy, with the private hospitals dictating costs.[24] Government hospitals become increasingly unreliable as a result, and there is an evident push from the private to the public sectors. The importance of "Corporate Social Responsibility" (CSR) and the "Welfare state" should be emphasised in order to combat this. CSR primarily focuses on the ethical responsibility of the healthcare system to carry out its responsibilities for the common good.

[21] *Id.* at 3.

[22] National Health Systems Resource Centre (NHSRC), Ministry of Health & Family Welfare, Government of India, *Emergency Medical Service (EMS) in India: A Concept Paper*, https://nhsrcindia.org/sites/default/files/2021-02/Emergency_Medical_Service_in_India_Concept_Paper.pdf (last visited May 24, 2023).

[23] Shishir Rajan Saha v. The State of Tripura, AIR 2002 Guwahati 102.

[24] Subhan I, Jain A., *Emergency care in India: the building blocks*, 3(4) INT J EMERG MED. 207, 207-11(2010).

Companies covered by Section 135 of the Companies Act 2013 are subject to it.[25]

Following their qualification under the aforementioned clause, they must spend a minimum of [25]2% of their average net earnings for three consecutive years.

The Indian Constitution's Articles 38[26] and 39[27] serve as the foundation for the Welfare State concept, and the state can execute this mandate by providing physical and financial support to private institutions that handle such cases. The state is required by the constitution to offer adequate medical services, even under Article 21. Therefore, both they and the general public should be aware of the responsibilities of the private and public healthcare sectors.

Thirdly, emergency response systems should be installed at common locations where fatal accidents occur, such as National Highways, to improve the odds of survival and address the unpleasant consequences within the "Golden Hour." Although it is present in a few locations, the quality of this care may be higher. 'Casualties' facilities, which are frequently staffed by junior specialty residents with no oversight and are merely'referral sites' for specialised treatment, offer emergency care.[27]

Therefore, it is important to clarify the Ambulance response time (ART). Because it directly affects people's lives, ART is the Key Performance Indicator (KPI) used to assess how well Emergency Medical Services (EMS) is performing. .[28] Response time is defined as the period of time between a patient calling for emergency services and the ambulance showing up, using a variety of methods and techniques used by various researchers. The waiting period is another name for this period.[29] One ambulance is required to serve a population of between 50,000 and 100,000 people, hence the emergency services that are now available cannot keep up with demand.[30] A study among pediatric emergency patients found auto-rickshaw, and not Ambulance as the most common mode of transport.[31] If significant steps are taken to fulfil the demand for ambulances and the crew that goes with them, the waiting time can be significantly reduced. It might require giving the personnel working in call centres and the actual emergency department the necessary training, as well as designating certain trucks and personnel to handle solely the pick-up of urgent patients.

Lastly, the advice provided by the Supreme Court in Paschim Banga Khet Mazdoor Samiti v. State of West Bengal[32] should be reviewed extensively.It correctly advises creating a Central Bed Bureau at the state level with the goal of controlling the availability of beds in emergency situations. This is absolutely necessary since it would reduce the trouble experienced by the parties engaged in medical emergencies by sending them straight to a healthcare facility that is equipped. The recent appearance of harmful viruses and diseases like COVID-19 serves as an example of the requirement for such coordinated systems. Additional recommendations can be adopted, such as teaching emergency

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[25] Companies Act, 2013, § 135, No. 18, Acts of Parliament, 2013 (India).

[26] INDIA CONST. art. 38.

[27] INDIA CONST. art. 39.

[27] Mavalankar DV., *Policy and management constraints on access to and use of life-saving emergency obstetric care in India,* 57(3) J AM MED WOMENS ASSOC 165, 168 (1972).

[28] Mukesh Shyamkant Desai, Dr. A. M. Rawani, M. I. M. Loya, *Reducing Ambulance Response Time in Emergency Medical Services: a Literature Review,* 2 IJBTRD 31, 31 (2020).

[29] Lee, Seokcheon, *'The role of centrality in ambulance dispatching'*, 54 IJDSS 282, 282–291 (2021).

[30] ASIAN HOSPITAL & HEALTHCARE MANAGEMENT, https://www.asianhhm.com/healthcare-management/emergency- services-india (last visited May 24, 2023).

[31] Sankar J, Singh A, Narsaria P, Dev N, Singh P, Dubey N., *Prehospital transport practices prevalent among patients presenting to the pediatric emergency of a tertiary care hospital*, 19 INDIAN J CRIT CARE MED. 474, 477 (2015).

[32] *Id.* at 8.

situations to use Code Red and making effective use of hospital beds.[33] It is also possible to consider the recommendations from the 2004 report on emergency medical care in India by the NHRC and the 201st Law Commission report.

Conclusion

In low- and middle-income nations like India, the development of effective emergency medical services (EMS) systems is essential for lowering morbidity and mortality.35 However, a lot of data points to India's subpar emergency medical care. India[34], the second-largest nation in terms of population, is in charge of both serving and safeguarding its citizens. Only when the significance of reform is understood is strict implementation of any legislation or action to strengthen the emergency department possible.

As a nation, we are worried about issues like the economy, national security, and health. However, we've overlooked the connection between these elements and our hospital's emergency room. Enhancing emergency medical services would benefit the nation's physical and mental health as well as the economy by improving employment and the life expectancy of dying workers.

Only if Indians are able to let go of the "not me" mentality will the first step in understanding the significance of the medical emergency department be achievable. Because many people think they are safe and won't have to deal with many problems in the future, it is necessary to challenge the residents' unpredictable mindset. To enhance the need for reform and drive the government to act towards it, we need to have a pessimistic outlook on the potential for lifetaking events on an individual level. In conclusion, the only way out is a joint effort between the government and the general public. To enhance the need for reform and drive the government to act towards it, we need to have a pessimistic outlook on the potential for life-taking events on an individual level. In conclusion, the only way out is a joint effort between the government and the general public.

[33] Misra A, Yadav DC, Kole T., *Emergency care in India beyond 75 years of independence - problems and solutions*, 13 J GLOB HEALTH 1, 3 (2023).

[34] Ravindra P, Bhat R, Karanth N, Wilson W, Lavanya BN, Umra S, Mahesh S., *Patterns and Predictors of Emergency Medical Services Utilisation by Patients Attending the Emergency Medicine Department of a Tertiary Care Hospital in IndiSa*, 15(2) J EMERG TRAUMA SHOCK 99, 99 (2022).