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"AN EMPIRICAL STUDY ON RIGHTS OF PATIENTS EMANATING FROM THE CONSTITUTION, HUMAN RIGHTS, CONSUMER RIGHTS, CODE OF MEDICAL AND NURSING PROFESSION:: A REVIEW OF JUDICIAL PERSPECTIVE"

AUTHOR'S NAME- SHIVAM

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An empirical study on Rights of Patients

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Introduction

Physicians in India have always held disproportionate power over their patients, and classical paternalism in physicians' behaviour is the rule rather than an exception.[1] Therefore, patients' rights in India are indirect rights, which arise or flow from the obligations of a physician or healthcare provider. Rights of patients in India basically emanate from the Constitution, human rights, consumer rights, code of ethics of medical and nursing profession.[2] Though, the Government of India has enacted plethora of legislations on health and healthcare, these legislations are piecemeal and address its objectives without contextualizing them in the overall context of patients' rights. Further, these legislations unfortunately does not mention about the patients' right and the observance of medical ethics.[3]

At present in India, if rights of patients are violated the only recourse for patients is to approach the courts and there are no alternative mechanisms for adjudication of their grievances. Patients have also become more aware of their rights. There are indications that in the future medico-legal casesmay not be restricted to the traditional medical negligence action, but may be openedout to the possibility of rights based actions brought by patients who wish to explorethe legal relationship with their doctor.[4]

This work of mine is a sincere effort in understanding the rights of patients in a broader framework encompassing both individual and social rights. I have made an attempt to outline what the current law is, why it is the way it is, as medicine brings with it specific emotive and moral complications. Empirical Data on the above-mentioned aspect has also been collected from the patients of CIP[5], RINPAS[6], and RIMS[7] and few private hospitals of Ranchi. Based on the inference achieved from scrutinizing and analysing of relevant empirical data; conclusion and suggestions have been formulated for the law in India keeping in view the ethical principles such as autonomy, beneficence, sanctity of life, dignity of the human person which has a greater role in reaffirming rights of patients. This work of mine tries to put forward some constructive suggestions and recommendations for effective protection of rights of patients in India.

[1]Ganesh AK. "AIDS in India", 82 *Postgrad Med J*. 545 (2006), p.546.
[2] M. GovindaRao, MitaChoudhury , *Health Care Financing Reforms in India*, Working Paper No: 2012-100, National Institute of Public Finance and Policy, March- 2012, p.2.
[3]SL Goel, *Primary Health Care Management*, Deep and Deep Publications, New Delhi (2004), p.2.
[4] Andrew Grubb, "The Emergence and Rise of Medical Law and Ethics", 50 *The Modern Law Review* 241 1987
[5] Central institute of psychiatry, Ranchi
[6] Ranchi institute of Neuro- psychiatry & Allied Sciences
[7]Rajendra institute of medical sciences, Ranchi

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Research Questions:

1. ***Whether the current law on Healthcare in India needs modifications keeping in view the ethical principles such as autonomy, beneficence, sanctity of life, dignity of the human person which has a greater role in reaffirming rights of patients??***
2. ***Whether is it necessary to have a shift from Doctor-centric care to Patient-centric care; creating trust, respect and emotional comfort for enhancing the quality of healthcare services in the long run??***

Right To Health And Healthcare: Judicial Perspective

When we look at right to health and healthcare in the legal andconstitutional framework, it is clearly evident that the Constitution and laws ofthe land do not in any way accord health and healthcare the status of a right.Though right to health has not been expressly incorporated in the Constitutionas a fundamental right, over the years it has acquired fundamental right statusthrough innovative judicial interpretation of Art.21 of the Constitution[8] andalso various Directive Principles of State Policy. Scope for such aninterpretation has been created by the dictum in ***"Maneka Gandhi v Union ofIndia"***[9] wherein, while interpreting Article 21 the Supreme Court held that theright to live is not merely confined to physical existence but it includes withinits ambit the right to live with human dignity. Accordingly, the State ismandated to provide to a person all rights essential for the enjoyment of theright to life in its various perspectives. Consequently, the right to health andaccess to medical treatment has been brought within the fold of Article 21.[10]

In **"*Consumer Education and Research Centre v Union of India"*[11],** the Court explicitly heldthat 'the right to health ... is an integral part of a meaningful right to life'. In**"*AkhilaBharatiyaSoshitKaramchariSangh*v *Union of India"***[12], the SupremeCourt pointed out that fundamental rights are intended to foster the ideal of apolitical democracy and to prevent the establishment of authoritarian rule, butthey are of no value unless they can be enforced by resort to courts.

[8]Article 21 provides that, 'no person shall be deprived of his life or personal liberty except according to procedure established by law'.
[9] AIR (1978) SC 597
[10](1981) 2 S.C.R. 516.
[11]AIR 1989 SC 2039.
[12]A.I.R. 1989 S.C. 2039.

Evolutionary Development Of Right To Healthcare

Ancient Period

In ancient period, medicine arose out of the primal sympathy of man withman.[13] It arose out of the desire to help those in sorrow, need and sickness. Inthose times, medical profession was however associated with superstition andmagic.[14] The sick person was believed to be under the influence of ghosts or evilspirit.[15] The first documented Code of Laws ever used by human civilisation is to be found from the *Code of Hammurabi*in Mesopotamia. In ancient Mesopotamia,medicine was considered as a part of 'magic'.

Medieval Period

There were no great contributions to the medical profession in the middleages. This may be attributed to the fact, that medicine was predominantly practicedby monks in monasteries. Due to this, medicine ceased to be a profession.[16] The church was more interested in preserving itself and its faith ratherthan focusing on protection of rights of patients.[17]A reading of religious books clearly conveys the message that physiciansshall protect and respect the rights of patients.Hinduism and Buddhism believe that all living creatures are manifestationsof the laws of *karmic* rebirth. [18]Islamic medical ethics is much more explicitly religious in tone.It worksvery closely with the Quranic texts which stand out as a perfect model for allmankind, all professionals and all time.[19]They include guidelines for thephysician's behaviour and attitude, both at the personal and professional levels.[20]

Modern Period

In 1803, Thomas Percival published *Code of Medical Ethics* which used theterm patient instead of sick. The Code became an influential guide for Westernphysicians rather than a work focused on ethical decision making.[21]With the formation of General Medical Council established by Medical Act 1858 and the Provincial and Surgical Association in 1832, which became the BritishMedical

[13] Douglas Guthrie, *History of Medicine*, Thomas Nelson and Sons Ltd., London, (1945), p.2, viewed 03rd may 2018, http://archive.org/details/historyofmedicin035119mbp.
[14] KPS Mahalwar, *Medical Negligence and the Law*, Deep and Deep Publications, New Delhi,(1991), p.1.
[15]Dan Mayer, *Essential Evidence-Based Medicine*, 2nd edn, Cambridge University Press, Cambridge 2010, p.2.
[16]ThaparRomila, *Ashoka and the Decline of the Mauryas*, Oxford University Press, Delhi (1973), p.154.
[17] Scorer G, "Moral Values, Law and Religion", in Scorer G and Wing A(eds), *Decision Making in Medicine*, Edward Arnold Publishers Ltd, London (1979), p.2.
[18]Manickavel V, **"**Love in Medical Ethics in South Asia"**,** 9 *Eubios Journal of Asian and International Bioethics* 40 (1999), pp.40-2;
[19] Veatch, RM (ed), *Cross Cultural Perspectives in Medical Ethics*, Jones and Bartlett, Boston (1989), p.120.
[20]Aasim I. Padela , "Islamic Medical Ethics: A Primer", 21 *Bioethics* 169 (2007), pp. 169-78;
[21]McCullough LB, "The ethical concept of Medicine as a Profession: Its origins in modern Medical ethics and implications for Physicians", in Kenny N, Shelton W (eds), 10 *Advances inBioethics* 17, Elsevier, New York (2007), at pp.17–27

Association in 1856, the nineteenth century witnessed institutionalization ofmedical ethics.[22]The tripartite international Bill of Human Rights Universal Declaration ofHuman Rights (UDHR), the International Covenant on Civil and Political Rights(ICCPR), and the International Covenant on Economic, Social and Cultural Rights(ICESCR) contained many principles and obligations that resembled norms of medical ethics[23]. It is true that until 1970s, giving protection to patients did not include ameaningful role for the patient in the decision-making process.[24] Reforms in healthsystems, progress in medical technology, respect for human rights, and otherrelevant factors like changing doctor-patient relationship have influenced patients 'attitudes towards health services.[25]

Role Of Ethics In Protection Of Patient's Rights

Medical Ethics is considered as one-sided; as it dwells on the ethicalobligations of doctors to the exclusion of those of patients. These are just guidelinesthat are imposed upon the professionals to ensure that their peers and also patientsfollow appropriate standards of moral decency. Medical ethics, through the ages, hasnot left contemporary society with a model that can be seen to be effective.[26] Evennow the Hippocratic Oath is still considered as an inspiration for the doctors and thebenevolent paternalism mentioned in it is accepted and respected by the physicians.

Medicine is an ethical profession and a doctor is deeply confronted withcomplex and sensitive medical issues coupled with the increasing public demand indecision-making process in the modern day advanced technological era.[27] Medical decisions were regarded as clinical matters best reached by the experts andanyone seeking to challenge a doctor's decision in the court faced an uphillstruggle.[28]The law sets down minimally acceptable standards,while ethical approaches may include deciding what would be the ideal way for aperson to behave. Medical law and medical ethics is closely connected.

[22] Andrew Grubb, *Principles of Medical Law*, 2nd edition, Oxford University (2004), p.83.
[23]DyaEldin M. Elsayed, RabaaElamin M. Ahmed, "Medical Ethics: What is it? Why is it important?" 4 *Sudanese Journal of Public Health* 234 (2009), p.285.
[24]Fallberg LH, "Patients' rights", in Vienonen M ed., *European health care reforms: citizens' choice and patients' rights*, World Health Organization Regional Office for Europe, Copenhagen(1996), pp.11–20
[25] Ronald MacKenzie C, "Professionalism and Medicine", 3 *HSSJ* 223 (2007)
[26]John R Carlisle, "Ethics and Bioethics", in Sandy Sanbar*et al*, *Legal Medicine*, 6th edn, Mosby (2001), p.228.
[27]Jonathan Herring, *Medical Law and Ethics*, 3rd edition, Oxford University Press, New York (2010), p.2.
[28] T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed., Oxford University Press, New York , (2001), pp.312-319.

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Right To Medical Treatment

A patient in receipt of medical treatment is entitled to respect for his or herautonomy, physical integrity and privacy, but the entirety of such rights' protectionpresupposes that the patient has access to the necessary medical treatment.[29] The 58thsession of the World Health Assembly in 2005 defined universal health care asproviding access to key promotive, preventive, curative, and rehabilitative healthinterventions for all at an affordable cost.[30] According to figures, roughly two billionpeople lack access to essential drugs or to primary health care. Millions are afflictedby infections and illnesses that are easily avoidable or treatable. In the developingworld many children die or grow stunted and damaged for lack of availabletreatments. Tropical diseases receive little or no attention by the majorpharmaceutical company's research departments.[31]

Judicial Response to Allocation of Scarce Resources

The first judicial recognition of the issue of limited resources came in ***"R v Secretary of State for Health, West Midlands Regional Health Authority and Birmingham Area Health Authority"***[32]when the Court of Appealapproved the view that the statutory duty, which could have provided a means toenforcing individual rights to healthcare, is subject to the implied limitation of finiteresources. It might, of course, remain open to a patient denied medical care to makean application for judicial review of that refusal. Unless there is some illegality orprocedural impropriety in the decision, however, the patient will face an uphillstruggle because irrationality will be very hard to prove. For example, in***" R v Secretary of State for Social Services"***[33], the Court of Appeal refusedleave to apply for judicial review of decisions to postpone a non-urgent operation ona premature baby. Sir John Donaldson held that the court could only intervene in theissue of allocation of resources where there is a failure to allocate resources andreferred directly to the public law concept of *Wednesbury unreasonableness*.[34]

[29]Elizabeth Wicks, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.17.
[30] M. GovindaRao, MitaChoudhury , *Health Care Financing Reforms in India*, Working Paper No: 2012-100, National Institute of Public Finance and Policy, March- 2012, p.2
[31]Mason, McCall Smith, Laurie, *Law and Medical Ethics*, 7th edn, Oxford University Press, Oxford, (2006), pp.416-17.
[32] [1980] 1 BMLR 93
[33][1987] 3 BMLR 32. The Court of Appeal refused leave to apply for judicial review of decisions to postpone a non-urgent operation on a premature baby.
[34]*Associated Provincial Picture Houses Ltd* v *Wednesbury Corporation* (1948) 1 KB 223. A reasoning or decision is Wednesbury unreasonable (or irrational) if it is so unreasonable that no reasonable person acting reasonably could have made it.

On the issue of standard of care of medical professionals, Indian courts hadadopted and still continue to follow the principle laid down in the *Bolam*[35]case whichheld that a doctor is not negligent if what he has done would be endorsed by a, responsible body of medical opinion in the relevant specialty at the material time.[36]Further, in ***"Jacob Mathew v State of Punjab"***[37]Supreme Court observed that a simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. In "***Indian Medical Association v V P Santha"***[38], the Apex Court decided that theskill of a medical practitioner differs from doctor to doctor and it is incumbent upon theComplainant to prove that a doctor was negligent in the line of treatment that resulted inthe death of the patient.

Patient's Right to Autonomy

The imperative of individual autonomy in healthcare is well described byJudge LJ in the case of **"*St. George's Healthcare NHS Trust v S"***[39]:

"When human life is at stake the pressure to provide an affirmative answer authorizing unwanted medical intervention is very powerful. Nevertheless, the autonomy of each individual requires continuing protection even, perhaps particularly, when the motive for interfering with it is readily understandable, and indeed to many would appear commendable…"

Patients cannot be required to accept treatment that they do not want, nomatter how painless, beneficial and risk-free the treatment may be and no matterhow dire the consequences of refusal of treatment.[40] This is because of the reason ofbodily inviolability.[41] To breach this, even in the most well-meaning way, is anaffront to notion of our bodily integrity.[42]

Consent to Treatment

Consent means an agreement, compliance or permission given voluntarilywithout any compulsion. It is a process of communication between a patient andphysician that results in the patient's authorization or it may be an agreement toundergo a specific medical intervention. According to the Indian Contract Act twoor more persons are said to consent when they agree upon the same thing in thesame sense. The Law perceives it as a contract. In medicine, the need for consentis the

[35]*Bolam*v *Friern Hospital Management Committee*[1957] 2 All ER 118.
[36]*AchutraoHaribhauKhodwa*v *State of Maharastra*1996 (2) SCC 634. T
[37](2005) 6 SCC 1.
[38]*Indian Medical Association* v *V.P. Shantha*1995 (6) SCC 651.
[39] [1998] 3 All ER 673,688
[40]*Sidway*v *Bethlem Royal Hospital* [1985] 1 All ER 643,649
[41] Marc Stauch, Kay Wheat, John Tingle, *Sourcebook on Medical Law*, 2nd edn, Cavendish Publishing Limited, London (2002),p.103.
[42]*Airdale NHS Trust* v *Bland* [1993] 1 All ER 821, 866.

legal expression of the principles of self-determination and autonomy.[43]

Express Consent

Express consent is where the patient demonstrates orally or in writing that heagrees to the treatment or procedure.[44] The Medical Council of India (MCI) has laiddown guidelines that are issued as regulations in which consent is required to betaken in writing before performing an operation. Unfortunately, the guidelines areapplicable to operations and do not cover other forms of medical treatment.In this type of consent, patient usually requires to sign a consent form provided by the concerned hospital. By signing this form, it is generally presumedthat the doctor has explained the proposed treatment and the procedures involved.Thereby, the patient cannot deny later. [45]

Implied Consent

Implied consent is frequently relied upon by doctors as a justification forcarrying out treatments or interventions upon patients. Implied consent is moreproperly understood as a species of estoppel.[46] Where a patient conducts himselfsuch that it is reasonable to imply that he consented to the treatment or procedure,the law merely prohibits the patient because of his conduct from denying that heconsented even though, in fact he did not. The extent to which consent may beimplied is, often, controversial. In ***"Mohr v Williams"***[47], a patient hadconsented to an operation on her right ear. During the course of the operation, thedoctor discovered that the right ear did not, in fact, need surgery, but the left ear wasin a more serious condition which required an operation. The doctor performedoperation, which was successful. The patient sued in battery. The main issue beforethe court was whether it could be argued that she had given an implied consent to anoperation on the other ear. The judge took the view that there was noimplied consent because the diseased condition of the patient's left ear was notdiscovered in the 'course of an authorized examination' of the ear, but in the courseof an examination which had not been authorized.

The 'Extension Doctrine'

The 'extension doctrine' allows the physician to go beyond the care thepatient authorized if an unexpected complication arises that makes it medicallyadvisable to do so. [48] The extension doctrine does not apply to elective ornonessential procedures, nor does it apply when the possible need for extension ofthe authorized procedure should have been anticipated by the physician prior tobeginning it. In such a case, the physician must inform the patient before the fact ofthe possible

[43] D. Feldman, "Human Dignity and Legal Values – Part II", 116 *LQR* 61(2000), p.67
[44] Andrew Grubb, *Principles of Medical Law*, 2nd edn., Oxford University Press, New York (2004), p.148.
[45] Picard, EI, "Legal Liabilities of Doctors and Patients in Canada", 2nd edn., Carswell, Toronto (1984),p.20
[46] Kennedy, I and Grubb, A, "Medical Law: Cases and Materials", 3rd edn, Butterworth, London (2000)
[47](1905) 104 NW 12.
[48]*Kennedy* v *Parrott* 90 S.E.2d 754 (N.C.1956).

need for extension and obtain the patient's express consent.[49]Autonomy is the underlying concept of modern human rights law. Theconcept of privacy has roots in the principle of autonomy which requires individualsto be as free as possible from external forces so as to enable their actions to reflect astruly as possible their autonomous choices and intentions.[50]

Patient's Right To Privacy And Medical Confidentiality

In the modern day most of the information acquired by physician is recordedand preserved at the hospitals and these medical records are no doubt regarded as theproperty of the hospital by law. Moreover, the duty to preserve confidentiality ofone's patients, which arises from the ethical principle of beneficence, is notabsolute.[51] There are circumstances in which medical professionals are encouraged oreven required to report their observations or patient test results to third parties,sometimes law enforcement officials, in which such a breach of duty has come to beseen as acceptable.[52] Of late, the medical community, the courts, and society havebeen struggling in particular with whether the breach of the duty of confidentialityby a physician is permissible or to be encouraged.

Ethical Obligation

A doctor's duty to respect his or her patients' confidentiality has its origin inthe first code of medical ethics. The Hippocratic Oath[53], states that:

"What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about. "

This concept of confidentiality, which underpins medical care, has withstood the testof time. This is obvious by the fact that the patient confidentiality receivesunqualified protection in the modern version of the Oath i.e., at the Internationallevel, the Declaration of Geneva[54]:

"I will respect the secrets which are confided in me, even after the patient has died."

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[49] Sandy Sanbar S *et.al.,Legal Medicine*, 6th edn., Mosby, Inc., USA (2004), p. 345.
[50]381 U.S. 479 (1965).
[51] American Medical Association's Code of Medical Ethics. Principle IV of the code states that a physician 'shall safeguard patient confidences within the constraints of the law'.
[52]*Tarasoff*v *Regents of the Univ. of Cal*., 551 P.2d 334 (Cal. 1976).
[53] Charles J. Sykes, *The Attack on Personal Rights-At Home, At Work, On-Line, and in Court*, St. Martin's Griffin, New York (1999), p. 98.
[54]Declaration of Geneva,viewed03/05/18,http://www.mma.org.my/Portals/0/Declaration%20of%20Geneva.pdf.

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Legal obligation

Themodern English law of confidence stems from the judgment in ***"Prince Albert v Strange"***[55], where Lord Cottenham, restrained the defendant from publishing acatalogue of private etchings made by Queen Victoria and Prince Albert.Therequirements for breach of confidence were laid down in ***"Coco v A N Clark"***[56], whereMegarry J developed an influential tri-partite analysis of the essential ingredients ofthe cause of action for breach of confidence: the information in question must have the necessary quality of confidence; the information must be imparted incircumstances importing an obligation of confidence; and there must be anunauthorized use of the information to the confider's detriment. According to thisthreefold test, legal protection would only be provided for personal informationwhere the confider and the discloser of the information are in a relationship ofconfidence.[57]Respecting a person's right to privacy-the right to decide who receivespersonal information and how it may be used requires that those privileged to haveaccess to such information maintain its confidentiality. [58]

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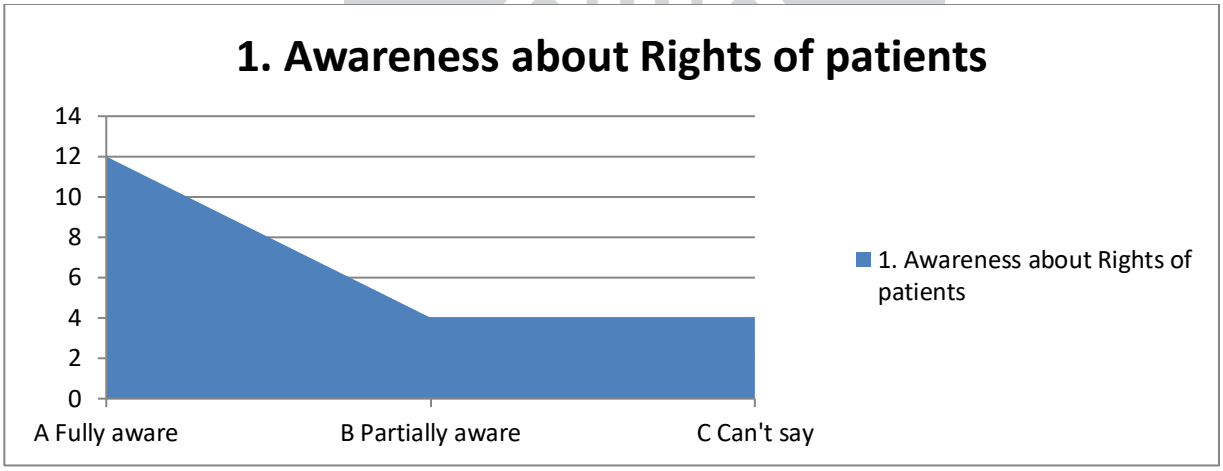

[55]*Prince Albert* v *Strange* (1848) 1 Mac.& G. 25.
[56]*Coco* v *A N Clark* [1969] RPC 41
[57]Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.122.
[58] S. Abraham, J. Prasad, A. Joseph, K. S. Jacob, **"**Confidentiality, partner notification and HIV infection: Issues related to community health programmes"**,** 13 *The National Medical Journal ofIndia* 207 (2000), p.208.

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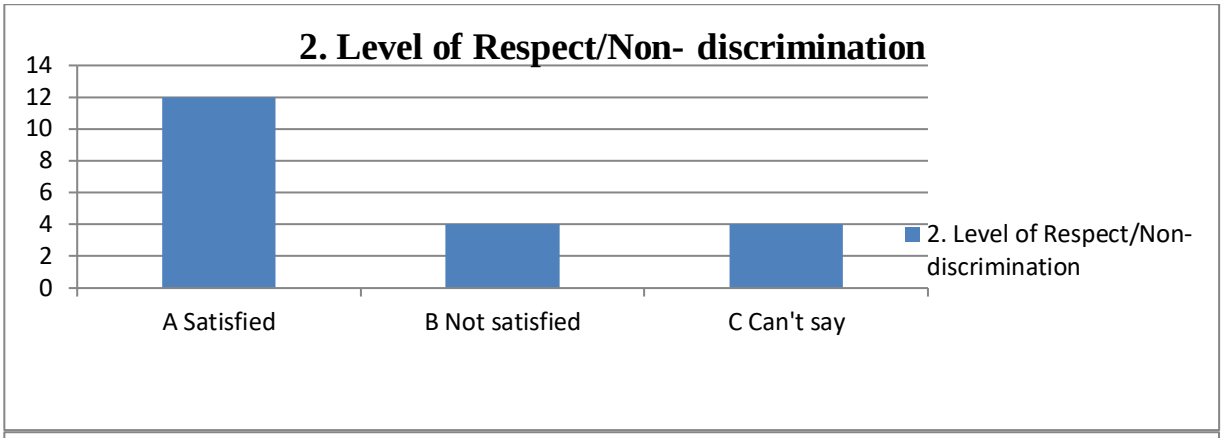

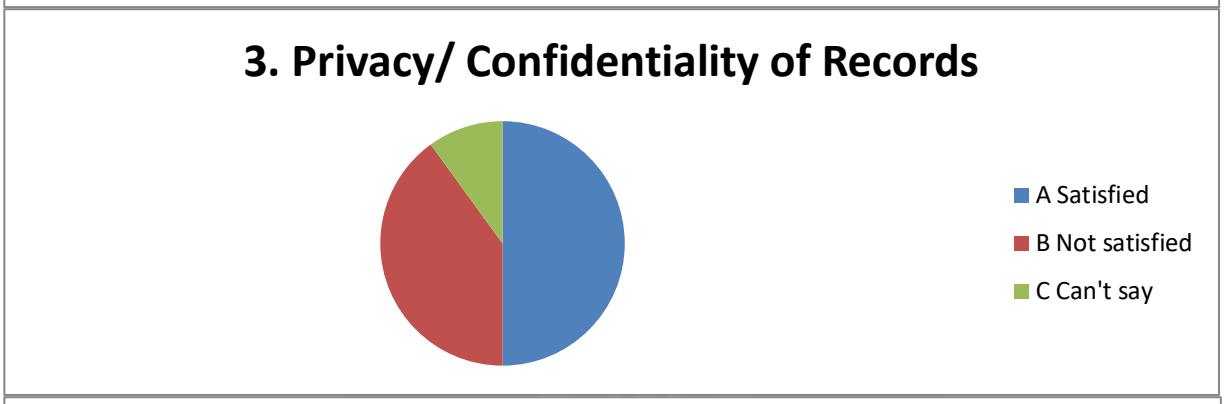

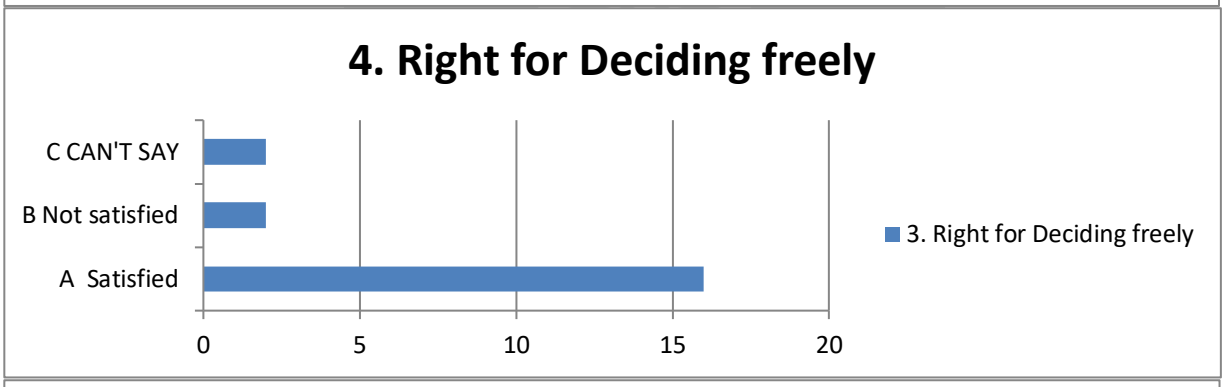

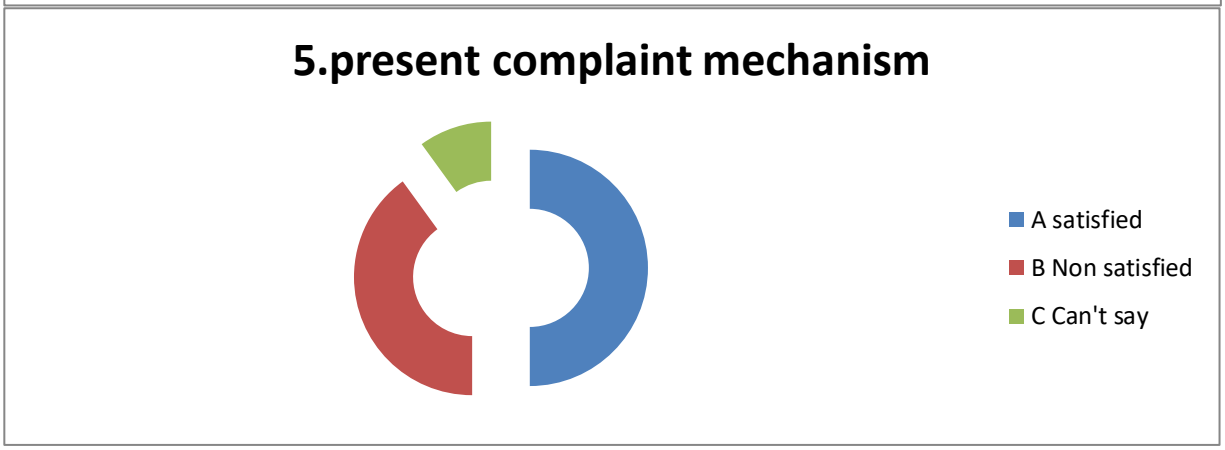

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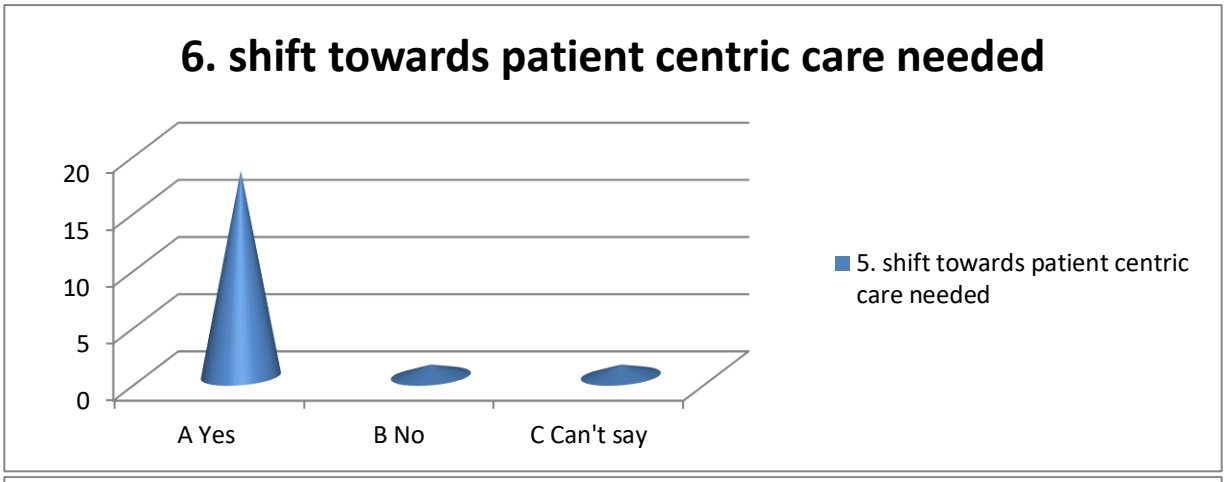

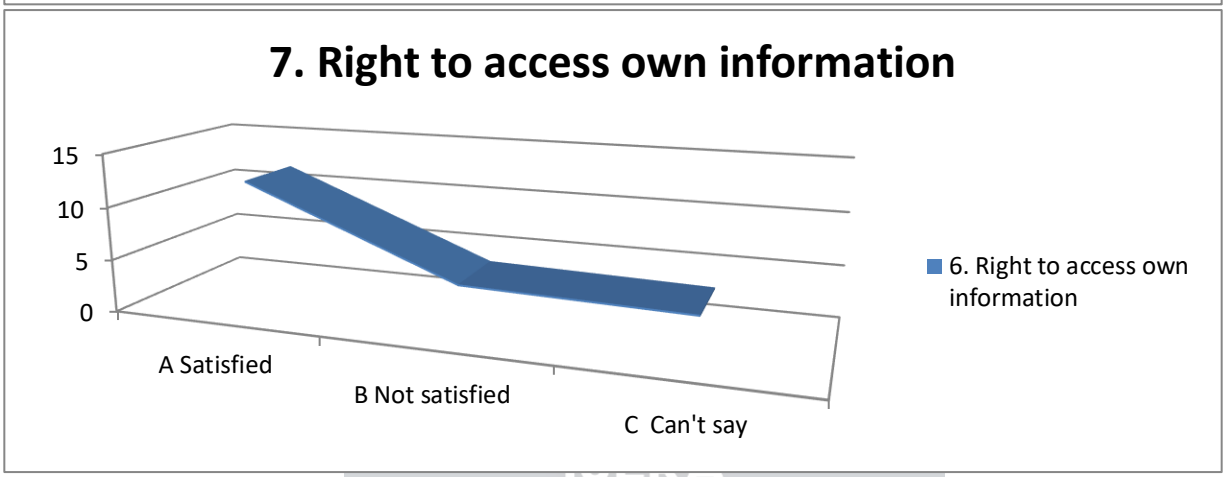

Analysis Of Collected Data And Findings

Major public and private hospitals in the city of Ranchi and entire population of Ranchi constitute universe for this present work. A sample of 20 respondents has been selected from these hospitals and surrounding areas to seek response of patients about their rights. The researcher found it difficult to collect information from illiterate and aged respondents. Some respondents refused to part with information due to their severe and prolonged illness. Closed -end questionnaire has been used to seek specific responses from the respondents. Opinions and views have been generated from doctors and officials in hospitals. For interpretation of data graphs, pie charts, bar diagrams etc. have been used. First part of questionnaire deals with profile of respondents. Second part of questionnaire consists of questions which are of immense relevance while discussing about patients' rights in Indian context.

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Chart-1 clearly points out that all the patients are not aware of their rights as patients; still there lies a large chunk of people who need to be taught about their rights as patients. Chart -2 throws light on the level of respect and notion of non-discrimination which is maintained by hospitals while treating patients. The close scrutiny of collected data shows that only sixty percent of patients are satisfied with prevailing norms in present context. Chart-3, Chart-4 and chart-7 throw light on patients' right to confidentiality, the rights of free decision making and right of having access to own information. The analysis of collected data reveals the fact that hundred percentsatisfaction is yet to be achieved in these fields. Fifty percent of Patients are not satisfied with present complaint mechanism and it can be inferred from cahrt-5. Ninety percent i.e. majority of respondents agree to the notion which demands a shift from doctor centric care to patient centric care.

Conclusion and Suggestions

Interestingly, in India the patients' rights have neither been expresslyenunciated through a statute nor through judicial decisions. The discussions in thechapters above and analysis of data collected brings to the light that it is the judicial decisions mostly from thewestern countries which has concretely put forward a mechanism to address thegrievance of the patients as these decisions have most often addressed the complexethical questions concerning the medicine and law. India lacks a concretemechanism through which patients' rights can be protected or guaranteed. Againstthis backdrop, following suggestions has been put forth so that specific rights ofpatients in India is protected and guaranteed.

Need for effective legislation to protect patients' rights

To provide a patient-centred healthcare it is essential that rights of patient'sare articulated clearly. In India, we have plethora of laws in the area of healthcarebut, as these laws lack organization and clarity, it creates confusion in the mind ofboth patients and healthcare providers. Moreover, in our country we neither havelegislation nor any patient's rights charter which specifically enumerates the rightsand responsibilities of patients. Thus strong and speedy steps must be taken in order to provide an effective legislation to protect patients' rights.

Need for evolution from Doctor –centric to Patient-centric Care

Laws and their enforcement no doubt play an important role in protectingrights of patients but these alone are not enough. What is necessary is to reinvent therelationship between doctor and patient.

In other words, there must be a shift from doctor-centric care to patient-centric care. Creating trust, respect and emotionalcomfort should be an important focus of the physician's responsibility and this willgo a long way towards enhancing the quality of healthcare services. This can bedone by the physician by giving emphasis on three important elements:**transparency, confidentiality, defining limits.**

Need for a stronger and effective Complaint Mechanism

The evidentiary burden, costs and delays associated with ordinary litigationmakes it cumbersome for enforcing patient rights in an effective manner. If patient'srights are to be meaningful, it must provide patients with an inexpensive, readilyaccessible, independent means by which to file a complaint and have it quicklyresolved. For example, in New Zealand, the health and disability commissioner usesvarious methods of dispute resolution, advocacy, mediation, etc., with a focus onpromoting resolution directly between providers and patients.

To conclude, the above mentioned suggestions and legal framework for protection of rights of patients if implemented will go a long way in guaranteeing the rights to patients in India.

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