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**Ina Raja**

# A Father's Crusade

## The Medical Murder of Ina Raja

Nirej Sekhon

**I**t was a seemingly innocuous stomach ache on the afternoon of June 13, 1996 that led to 14-year-old Ina Raja's death two days later. Ina was a healthy and active child. Her interests ranged from trekking to classical dance. Thus, when she complained of stomach pain, there was little reason for her parents to be overly concerned. Dr Raja Ram, Ina's father, even recalls hearing Ina singing soon after reporting her gastric discomfort. With the passage of a few hours, however, Ina's stomach ache grew worse. In response, her father took Ina to see a local doctor. He suggested she may have appendicitis. The doctor recommended confirming the tentative diagnosis by having a blood test followed by more extensive tests in the morning. The doctor also gave Ina an injection which eased her discomfort. By 10 pm, Ina seemed to have staged a full recovery: her pain dissipated and the blood test result was normal.

The following morning, Ina's father took her to see their family doctor. He ruled out the possibility of appendicitis, but recommended obtaining a second opinion. In the quest for a second opinion, Dr. Raja Ram and Ina visited Mata Chanan Devi Hospital. It was the nearest hospital approved by Delhi University, Dr. Raja Ram's employer

and health insurance provider. At the hospital, two surgeons, Dr. A.J.S. Gulati and Dr. Vimal Jain examined Ina. The doctors performed the examination hurriedly, scarcely allowing Ina's father to explain the reason for their visit. They quickly concluded that Ina suffered from "acute appendicitis". Their conclusion was surprising in the absence of further diagnostic testing and given that Ina was in no apparent pain.

Dr. Raja Ram attempted to question the doctors' conclusion. They, however, insisted that he was being foolish for being concerned about such a "simple procedure" — an appendectomy. Gulati and Jain strongly recommended performing the surgery immediately. When Dr. Raja Ram insisted on first reconsulting his family doctor, Gulati and Jain threatened that Ina's appendix could rupture at any moment. Despite the doctors' use of "scare tactics", a nervous Dr Raja Ram left Mata Chanan Devi to reconsult his family doctor.

When presented with the new diagnosis, their family doctor deferred to the surgeons on account of their status as "surgeons". By one o'clock in the afternoon, Ina's family had checked her into Mata Chanan Devi Hospital for an appendectomy. In the hour before the surgery, the hospital's staff made no effort to ascertain Ina's medical history. In fact, there was no pre-operative

preparation or consultation whatsoever. At 2 pm a nurse arrived in the waiting room with a wheel chair to transport Ina to the operation theatre. A buoyant Ina insisted on walking unassisted into the OT. There are not many ethical practitioners who would allow a completely unprepared patient to simply walk into the operating theatre.

Little did Ina's family know that the "simple appendectomy" would never even begin. Gulati emerged from the OT two hours after Ina had walked in on her own. He informed the family that the operation had not been performed on account of an anaesthesia complication. Gulati, however, assured them that Ina was out of danger. Gulati also told them that Ina would be transferred to the Intensive Care Unit (ICU) for "stabilisation". Why anyone who was "out of danger" would have to be "stabilised" is a question Gulati did not bother to answer.

Two hours after Gulati reported that she was "out of danger", an oxy-gen-mask clad Ina was rushed from the OT to the ICU. Ina's family spent most of the night trying to ensure that hospital staff monitored Ina's condition. This was no easy task given that the doctors and nurses "on duty" spent most of their shifts sleeping. Even worse than the ICU staff's somnolence was the absence of any specialist who could handle Ina's case. At 9.15 the following morning, an anaesthesiologist finally

arrived. At two o'clock, Dr Raja Ram's family received the welcome news that Ina was almost "out of danger". Any sense of relief, however, was fleeting. A mere hour later, hospital staff told the family that Ina had died of "cardiac arrest" in the ICU.

"Cardiac arrest" is a horribly vague explanation for the death of a 14-year-old appendectomy patient. Hospital staff, however, were disinterested in the family's aggrieved pleas for a more substantive explanation. The hospital not only denied their request for Ina's medical report, but demanded full payment for the procedure. However, Dr. Raja Ram refused to pay anything more than what he had already paid in advance. When Ina's family finally obtained the hospital report what they found was a largely fabricated account of their daughter's death. The hospital report contends that precautions were taken and tests performed when they actually were not. Seven months later an independent medical board commissioned by the Delhi government began to provide some of the answers that the hospital staff were either unwilling or unable to give.

Even the report of this board is not conclusive. This is partly due to the absence of a post-mortem examination. It is also due to the fact that it was based entirely on interviews with Mata Chanan Devi doctors and hospital records. The distortions in the hospital records are thus reflected in it. For instance, the audit never questions the accuracy of the surgeons' initial diagnosis of "acute appendicitis". Rather, the audit simply accepts that the diagnosis was appropriate because the hospital records claim that all the necessary tests were performed.

The audit obliquely suggests that medical negligence occurred in relation to complications arising from the improper administration of anaesthesia. The anaesthesiologist chose to use a spinal anaesthesia for Ina's appendectomy. Administering spinal anaesthesia is rather complicated. Spinal anaesthesia is injected directly into the spinal cord. It is crucial that the patient remain motionless so as to ensure that the anaesthesia does not travel upward to the brain. In cases where this occurs or where the dosage is too high, the brain's vital centres may be affected. In addition, there is the danger of extracting too much spinal fluid when administering the anaesthesia. This also causes severe damage to the brain. The enquiry vaguely suggests that the doctors may have given an excessive dosage of anaesthesia. Thus, Ina may have died because of an extreme allergic reaction. Dr. Raja Ram later came to know through reliable sources that the anaesthesia was administered by the surgeon himself, not a professional anaesthetist because

the hospital in its hurry to go ahead with the operation was not able to arrange for one in time. However, it is also possible that she died as a result of serious damage sustained by her air passage. The repeated insertion and removal of an endotracheal tube without muscle relaxants may have caused major trauma to her airways. Due to serious "gaps" in the hospital report, however, it is impossible to definitively say what actually happened. The enquiry's report only conclusive assertion regarding negligence is that the doctors failed to keep the complete record of the relevant clinical facts. This indictment seems rather feeble in view of the full account of Ina's death. It would seem that even a minimal account of negligence/malpractice in this case would have to take into consideration all of the following issues:

- a) the surgeons made an initial diagnosis of "acute appendicitis" without performing the proper medical tests;
- b) the surgeons' use of high pressure "scare tactics" in an attempt to coerce Dr Raja Ram into



Ina's parents : Dr Raja Ram and Susheela Raja

- agreeing to the surgery without allowing him sufficient time to obtain another opinion;
- c) the absence of any sort of pre-operative consulting (inquiring as to patient's medical history) or preparation of the patient for surgery;
  - d) the inadequacy of ICU staffing;
  - e) the hospital's failure to recommend an autopsy examination (as should be standard in cases where cause of death is questionable);
  - f) the hospital's refusal to turn over patient's record upon demand; and
  - h) the fabrication/incomplete state of hospital records.

Of these issues, the medical enquiry only partially addresses the last one concretely. This report does not even begin to take into consideration the full dimensions of medical negligence in this case. What is remarkable is how much effort Dr Raja Ram's family has had to invest to have even this meagre audit performed.

The Rams' campaign for redress has been five fold:

- Alerting local police,
- Alerting the media,
- Organising social opinion against Mata Chanan Devi Hospital,
- Demanding the Delhi Administration's attention, and
- Filing a case in the National Consumer Disputes Redressal Commission.

In the immediate wake of her younger sister's death, Ira Raja filed a First Information Report with the West Delhi police and notified the media. Although the police began an investigation, no arrests were made until a year later. Alerting the media, however, had virtually instant results. News of Ina's death appeared in most Delhi dailies. Dr. Raja Ram's family believe that media generated public awareness has



**Ina with her parents**

made it more difficult for the bureaucracy to ignore their case. In a further effort to highlight problems at Mata Chanan Devi Hospital, Ina's family organised a protest demonstration in front of the hospital on June 28, 1996. Participants included school children, the Delhi University Teachers Association (DUTA), and the parents of Urvashi Aggarwal, a 5-year-old girl who died at Mata Chanan Devi in 1995. Urvashi was checked into Mata Chanan Devi for minor nose surgery, but ended up dying due to an anaesthesia overdose. DUTA's President demanded that Mata Chanan Devi be removed from the University panel while others joined in denouncing the hospital. Despite these early efforts, securing the Delhi Administration's attention was most important and most difficult. Towards this end, Ina's family benefitted from the assistance of an influential and genuinely concerned Delhi based industrialist, Gun Nidhi Dalmia.

Dalmia's daughter attended the same school as Ina Raja. As a result of the two girls' friendship, Dalmia had seen Ina on a few occasions. The news of her death did not jibe with Dalmia's recollection of his daughter's healthy, vibrant playmate. Consequently, Dalmia

wrote a lengthy letter demanding an official response to Ina's death. The letter was sent to several government agencies and officials including the Delhi Health Council, the Human Rights Commission, and the Principal Health Secretary (Delhi Administration). Dalmia's letter, coupled with assiduous follow-up by Dr. Raja Ram and Dalmia, precipitated two Human Rights Commission meetings. The Commission convened the meetings to discuss the general conditions prevailing in Delhi's nursing homes with emphasis on Ina's case. These meetings helped facilitate the partial realisation of Ina's family's desire to see an independent medical audit of Mata Chanan Devi Hospital performed.

Dr. Raja Ram had repeatedly appealed to the Principal Health Secretary that a proper independent enquiry committee be instituted to audit three years of Mata Chanan Devi's medical records with emphasis on cases of anaesthesia related deaths. While the Principal Health Secretary, eventually did setup the above mentioned enquiry, but its mandate was to limit itself to Ina's case. Perhaps more troubling is his decision to base the board's findings primarily on the hospital's records.

Dr. Raja Ram repeatedly requested that the board include his narrative of Ina's death in their audit. The Delhi Administration never dispatched an official response. In a private meeting, however, the member Secretary, Medical enquiry board intimated to Dr. Raja Ram that including his account would bias the Board's report. As suggested above, however, it would seem that the report ultimately produced is far from unbiased.

The medical audit, completed on January 27, 1997, only vaguely suggests that the doctors at Mata

Chanan Devi were negligent. As mentioned, the audit never asks how Ina ended up in Mata Chanan Devi in the first place. Nonetheless, on the basis of this audit, the West Delhi police finally took action in April, 1997 and all the 8 doctors involved in Ina's treatment were arrested on charges of

criminal negligence. But they were all released on bail. In addition, the audit should be helpful for the Dr. Raja Ram's pending case in the National Consumer Disputes Redressal Commission. The family filed this case against Mata Chanan Devi Hospital on October 10, 1996.

Despite the excitement surrounding the Supreme Court's extension of the Consumer Protection Act (COPRA) to medical services in 1995 (see box), Dr Raja Ram's experiences attest to the persistent difficulty in obtaining compensatory damages in cases of gross medical

## The Consumers' Protection Act (COPRA)

On 13 November 1995, the Supreme Court passed judgment on Civil Appeal Number 688 (filed by the Indian Medical Association) and officially extended the Consumer Protection Act (COPRA) of 1986 to medical services. The main legal questions answered by the Court were: (a) whether medical services were consistent with COPRA'S definition of "services" and (b) whether people who avail of medical services could be defined as "consumers". COPRA defines a service as a "service of any description" which is exchanged for some consideration regardless of whether promised, partly paid, or paid in full. COPRA'S definition excludes services that are rendered free of charge or under a contract of personal service (a contract that entails some sort of master/servant arrangement). COPRA defines a "consumer" as any person who avails of "any service" (as per COPRA'S definition of a service). The exclusion of services rendered free of charge is rather severe. It, in effect, denies protection to recipients of "free" government health-care. COPRA is, thus, virtually meaningless for the vast majority of India's poor.

Those who COPRA defines as "consumers" have the specific rights enumerated below:

1. *The Right to Safety*, consumers should be protected against products and services which are hazardous to health and life.
2. *The Right to be Informed*: consumers should be given the facts necessary to make informed decisions.
3. *The Right to Choose*: consumers should have access to a variety of products at competitive prices.
4. *The Right to be Heard*: consumer interests should receive full and sympathetic consideration in the formulation and execution of economic policy.
5. *The Right to Redress*.
6. *The Right to Consumer Education*: consumers should have access to the knowledge and skill necessary to be an "informed consumer".

A "consumer" may file for a claim in the Consumer fora if she feels she has received a "deficient service". COPRA defines "deficiency" as any "fault, imperfection, shortcoming, or inadequacy in the quality, nature, and manner of performance which is required to be maintained under the law. Redress for a "deficient service" may be sought at three different levels: the (1) District Forum, (2) State Commission, and (3) National Commission. The value of services claimed may not exceed Rs 5 lakh and Rs 20 lakh in the District fora and State Commissions respectively. The National Commission will hear cases for claims over Rs 20 lakh. The State and National Commissions are also responsible for hearing appeals (National Commission rulings may be appealed to the Supreme Court).

Each of the fora is constituted by a President and two other members who have "standing" and are experienced in dealing with problems related to law, economics, public affairs, etc. (four such members sit on the National Commission). The President of any fora must be a person who has been or is qualified to be a judge in a court of the same level (i.e., a District Forum President is someone who is qualified to be a District Court Judge).

Litigants must file complaints within two years of their cause of action. Filing a complaint, however, does not guarantee that the consumer fora will hear your case. The fora will only hear cases of "obvious medical negligence;" that is, cases which do not require much evidence to either prove or disprove that medical negligence has occurred. This may include cases of death, removal of an incorrect limb or organ, etc, the fora will not hear cases which require extensive examination/cross-examination of expert witnesses. Cases where expert testimony may be restricted to written statements are preferred. The fora does, however, reserve the right to call witnesses when necessary.

Unlike in civil courts, one need not pay any sort of fee to file a case under COPRA. The consumer fora, however, may impose fines for what they deem to be "frivolous" complaints, the amount of the fines may vary, but cannot exceed Rs, 10,000. Admittedly, few cases filed are actually heard by the consumer fora. Nonetheless, most agree that, however meagre, COPRA is a desperately needed step forward.

negligence. It took four months just to find doctors willing to testify on their behalf. Many doctors privately confirmed that Mata Chanan Devi's doctors were negligent, but absolutely refused to do so in any sort of public setting. Finding a reliable lawyer has also been a struggle. Technically, litigants can argue their own cases in a consumer forum. However, Dr. Raja Ram fears that he will be no match for the battery of lawyers Mata Chanan Devi is sure to have.

Dr. Raja Ram's COPRA case is far from settled. The family describes the whole process thus far as nothing less than "tortuous". However, when asked if they have ever considered quitting, Dr. Raja Ram answers with a definitive "no". He and his family feel a certain social responsibility to other parents and would not like to see this happen to another child.

They have been more successful in their pursuit for redress than most other families. Still, one should not exaggerate their "success". They have had to use all their energies to obtain a half-hearted response from the bureaucracy. One wonders what people without Dr. Raja Ram's resources and connections are to do in cases of medical victimisation.

The Rams have kept their campaign against Mata Chanan Devi Hospital alive. On June 14, this year, the first death anniversary of Ina, the family along with friends and many sympathisers went around 500 houses to mobilise people to come for a demonstration and *dharna* in front of the hospital. The aim of organising the *dharna* was to create a forum for people to share their experiences at the hands of doctors of Mata Chanan Devi Hospital. They would then get together and file a Public Interest Litigation case against the hospital and its staff. About six or seven people had similar accounts of having been victimised by the

doctors of the hospital. Other events at the *dharna* included a skit on the subject of medical malpractice performed by the Nishant Natya Manch of Delhi University, and walking around the hospital thrice, shouting slogans against the hospital's negligence.

Sustaining the Rams in their struggle to get justice is the memory of their daughter and their determination to bring the guilty to book. Says Dr Raja Ram: "Every day many people who come for treatment to the doctors get death instead. I know the medical profession is overburdened but to a great extent it is their own creation. We know that

there are good doctors too and we must do something to encourage this rare breed of doctors by exposing the corrupt and irresponsible ones."

Lending urgency to the Rams' campaign is the realisation that the path of justice is very slow. Dr. Raja Ram says he cannot wait for justice to take its normal course since he is over 60 years old. For the future, he plans to organise more demonstrations, meet afflicted families and spread awareness amongst people. He is convinced that if he gets more public support he would not only succeed in getting redressal for Ina's death but also prevent more such deaths in the future. □

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## Medical Malpractice

### Review of Available Legal Remedies

GENERALLY, it is only the more gruesome cases of medical abuse and malpractice which receive extensive media attention. In practice, a whole range of less sensational unethical medical practices receive little or no attention. Expensive but unnecessary tests and surgeries are frequently prescribed in Delhi's private hospitals and nursing homes. Many times such surgeries are performed by insufficiently trained doctors in poorly equipped operation theatres. The problem has grown particularly severe in the last couple of decades. Patient discontent seems to have risen proportionately. The extension of the Consumer Protection Act (COPRA) to medical services in 1995 was a tentative response. To date, however, COPRA has been largely effective in bringing about a sense of accountability in the

medical profession. The continued lack of accountability, combined with growing commercialization, has made the medical profession ever more irresponsible.

#### Private Sector Practice

Roughly 80 percent of medical services in India are provided through the private sector. The private medical sector's dramatic growth, in part, reflects the inadequacy of the public health sector. While the public sector witnessed substantial investment through the '60s, it has stagnated since. Most government hospitals provide abysmally poor service. The decline of public health services has been synchronous with a dramatic increase in the number of doctors in cities. The consequent growth of the urban, private medical sector has been almost totally unregulated.

Over-treatment has become common at all levels in private practice. Virtually every medical speciality has at least one operation which is thought of as a bread and butter procedure. In most cases, these surgical procedures are expensive. More importantly, bread and butter procedures are ones that doctors can easily describe as routine. Therefore, it is easy to lure patients into having such surgeries when totally unnecessary. Unnecessary appendectomies, hysterectomies, to name just two such procedures, are performed with alarming regularity in Delhi's private nursing homes. Similarly, prescribing expensive but unnecessary diagnostic tests and medications has become commonplace. Where X-Rays may have once been the test of choice, now it is MRIs and ultrasounds. Often, it is referral networks that facilitate such profiteering. Informal agreements between doctors, pharmacists, and testing facilities have become the norm. In such arrangements, referring physicians receive a kickback for all referrals made to a particular pharmacist or testing facility. Dr. Puneet Bedi notes that general practitioners are frequently the "gate-keepers" of such networks. After all, their office is often the patient's first stop.

### **Reckless Profiteering**

Profiteering is an issue in all countries where there is substantial private sector health care. In India, however, profiteering is often completely reckless. Nor is it restricted to the private sector. Doctors in government hospitals may also use their positions to earn income from private practices they run on the side. Along with over-treatment, commercializations has created new incentives for gross acts of medical malpractice. Everything from "scare tactics" to false diagnosis may be

used to "force" a patient to consent to a procedure. Moreover, there is a material incentive for physicians to "cut corners" when it comes to maintaining equipment and taking basic precautionary measures. Physicians often overstep their professional training to make money. Safety suffers in the interest of maximizing profit.

Unfortunately, there is no mechanism to ensure that hospitals adhere to a minimum safety standard. Nor is there a mechanism to ensure that surgeons are trained to perform the operations they claim they are capable of performing. Specialization is not certified by any sort of centralized body. Technically

speaking, anyone with an MBBS can perform whatever procedure he sees fit to undertake. It is this utter lack of institutionalized accountability that allows reckless profiteering to go unchecked.

### **No Accountability**

The medical fraternity has done little to seriously address the lack of institutional norms and accountability within the profession. This is particularly shameful given that these problems manifest themselves from the lowest levels upwards. Despite dramatic technological changes in medical science, medical education in our country has remained largely unchanged since the 1960s. This is a



particularly serious issue for schools that are far removed from urban centres. Dr. Mathew Verghese, an orthopaedic surgeon, argues that in the absence of any rigorously enforced all India standard, there is a sizeable discrepancy in skills and knowledge between doctors emerging from India's best and worst medical colleges.

Technically, it is the responsibility of the Medical Council of India (MCI), created in 1956 and composed of doctors, to monitor and maintain basic standards of medical education. The Council, however, has done little to see that medical education has kept pace with the times. The MCI's state level incarnations have been similarly ineffectual. Doctors are supposed to register with the Medical Council of the state in which they would like to work. As mentioned, however, the MCI does not expect doctors to register as specialists in a particular field. They simply practise whatever they want to.

Once registered with the MCI one literally becomes a doctor for life. A doctor's registration is not at all dependent on periodic reexamination or reassessment. In fact, there is no mechanism to ensure that registered doctors keep abreast of the latest developments in medical science. A doctor registered in 1967 could easily have practised for the last 30 years without learning any of the new techniques or technologies that have been developed since she/he initially registered. There is currently a movement to create a "continuing medical education" (CME) requirement for all registered doctors.

However, it remains to be seen what becomes of this movement. For now, the only real punitive action the MCI can take is to revoke a doctor's registration. Even this, it almost never does. Dr. Bedi goes so far as to say that the MCI is little more than a



**Mata Chanan Devi hospital in west Delhi**

"coterie of doctors" that has acted in the interests of other doctors. Patients' rights have never been a real concern. The MCI's failures raise important questions about the medical community's commitment to internal auditing and self regulation. Surely, there are many individual doctors who are committed to providing ethically sound care for their patients. However, there is no such commitment at an institutional level. The Indian Medical Association (IMA), India's premier doctors' organization, goes so far as to deny the existence of a serious medical negligence problem. Dr Prem Aggarwal, General Secretary of the IMA asserts not only that, "...it is not possible that medical negligence is out of proportion," but, that, "...the interests of the medical profession...is what interests society". The IMA's rhetoric tries to erase patients' vulnerability in the current system. In the absence of any real interest in patients' welfare, the IMA has unscrupulously pursued doctors' interests at the expense of patients interests. Sadly though, in Dr Bedi's words, "doctors are organized and patients are not". What this ultimately means is that

doctors are well positioned to resist most medical reforms proposed by consumer and patients' rights groups.

### **Poor External Controls**

External controls (meaning controls imposed by entities outside the medical fraternity) are inherently limited in a way that internal auditing is not. External controls, in most cases, are punitive and "after the fact". That is, they seek to provide relief once medical negligence has already occurred. In the few instances where external regulations could provide preventative protection they have not been enforced. Nursing home registration/regulation is one such instance.

In Delhi, private nursing homes are required to register with the state (as per the Delhi Nursing Home Act of 1953) and, thus, submit themselves to periodic inspection. Less than 10 per cent of private nursing homes in Delhi are actually registered. For those that are, it is not clear that inspection is anything more than a formality. Mata Chanan Devi Hospital is among the 10 per cent of the hospitals that are registered. Without a mechanism for enforcement, the Delhi Nursing Home Act has become



a meaningless law. The same may be said of most of the criminal and civil laws designed to protect patients. Criminal cases are rarely pursued by the police while civil cases are known to take notoriously long. Neither has regularly acted in the interest of protecting patients. Organizations such as the IMA, however, have actively resisted reform efforts. When the Supreme Court officially extended the Consumer Protection Act (1986) to medical services in 1995, the IMA was at the forefront crying foul and continues to do so.

### Patients as Victims

Consumer groups received the Supreme Court's 1995 decision with fanfare. By allowing litigants to represent their own cases and permitting affidavit testimony, COPRA Fora hoped to offer verdicts in as little as 90 days. In principle, the consumer fora function on the same basis as civil courts (i.e., torts law). In view of this, it is somewhat difficult to understand why the IMA has protested so vociferously. The IMA argues that COPRA is bad for both doctors and patients. The IMA contends that COPRA has made it easier to file frivolous cases against doctors as well as making it necessary for doctors to practice "defensive medicine;" that is, to prescribe more tests than necessary to ensure they are not sued.

Surely, a few cases may have been unnecessarily filed against some well meaning, practitioners. It is not clear, however, that many such cases have resulted in decisions against doctors (see, "C.P. Act and doctors", The Hindu, December 25, 1995) There is a stipulated Rs 10,000 fine for filing "frivolous cases". In so far as practising "defensive medicine" goes, the IMA's predictions were a reality before COPRA. Profit motivated over-treatment has been the norm for



quite some time. Ultimately, it would seem that the IMA is only concerned with the possibility that their members might actually be held accountable for what they do. The real question is whether COPRA has improved accountability in the medical profession.

In the year since the Supreme Court's decision, there is little to suggest that COPRA has made much difference. Enough cases have been filed to slow down work of the fora significantly. Officials admit that the work of the fora are understaffed for the number of cases that have been filed. Once upon a time, a verdict was promised in 90 days; it now takes one to two years at least. Most of the cases filed, however, receive short shrift. The consumer fora will only hear cases of "obvious negligence". Most cases filed are not deemed to meet this criterion. Predictably, doctors have done little to make the process easy. Some doctors charged with negligence simply shift to new institutions, making it difficult for the fora to find them ("Little succor for litigants...", The Statesman, January 25, 1997) Assuming that the fora agrees to hear one's case and the doctor accused does not go into hiding, it

is still difficult to pursue a case. Ina Ram's case attests to this.

### Legal Limitations

Proving medical negligence requires substantial documentation and expert testimony. Often, hospitals and/or doctors are unwilling to surrender patients' records, despite the patients' legal right to access. When such documents are eventually turned over, they are often incomplete or fabricated. In such cases a postmortem study is essential. A litigant, will almost always require some sort of expert testimony to back up her case. Doctors, however, are exceptionally reluctant to testify against one another. Doctors interviewed for this article offered some speculation as to why this might be. Perhaps doctors fear being in the same position in the future as those they are testifying against in the present. Perhaps they fear ostracism. Ostracism can have serious financial consequences given the prevalence of referral networks. Perhaps it is simply social pressure from the fraternity. Whatever the reason, it is obvious that most doctors are more interested in protecting colleagues than they are in protecting patients' rights or the integrity of the medical profession.

Although COPRA is a step in the right direction, it is far from a total answer to the negligence problem. Dr Verghese contends that without a serious commitment to internal auditing from the medical fraternity, COPRA will never function as intended. The irony, of course, is that if the medical fraternity had been committed to internal auditing from the onset, COPRA probably would not have been necessary. As it stands, the burden of ensuring that one is receiving ethically sound health care is very much on the patient's shoulders. □