

LAW COMMISSION OF INDIA

201<sup>ST</sup> REPORT

ON

EMERGENCY MEDICAL CARE TO VICTIMS OF  
ACCIDENTS AND DURING EMERGENCY MEDICAL  
CONDITION AND WOMEN UNDER LABOUR

( Draft Model Law Annexed )

AUGUST 2006

## JUSTICE M. JAGANNADHA RAO LAW COMMISSION OF INDIA

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Dear Shri Bhardwaj Ji,

Sub: 201<sup>st</sup> Report on “Medical Treatment after Accidents and During  
Emergency Medical Condition and Women in Labour”.

The Supreme Court of India as long back as 1989 observed in Parmanand Katara v. Union of India AIR 1989 SC 2039 that when accidents occur and the victims are taken to hospitals or to a medical practitioner, they are not taken care of for giving emergency medical treatment on the ground that the case is a medico-legal case and the injured person should go to a Government Hospital. The Supreme Court emphasized the need for making it obligatory for hospitals and medical practitioners to provide emergency medical care. This is not the only reason for not attending on injured persons or persons in a medical emergency, for sometimes such persons are turned out on the ground that they are not in a position to make payment immediately or that they have no insurance or that they are not members of any scheme which entitles them to medical reimbursement. The Supreme Court reiterated its views in Paschim Banga Khet Mazdoor Samithi v. State of West Bengal, 1996 (4) SCC 37 and National Consumer Redressal Commission has also decided in like manner in Pravat Kumar Mukerjee v. Ruby General Hospital (25.4.2005). The Law Commission has, therefore, taken up the subject suo motu in view of the observations of the Supreme Court in Parmanand Katara.

Indifference towards victims of accidents and those in emergency medical conditions and even women under labour who are about to deliver is not peculiar to India but is prevalent in other countries also. In the United States, there is a statute called EMTALA (Emergency Medical Treatment and Labour Act) which was enacted by introducing it in 1986 into the Consolidated Omnibus Budget Reconciliation Act, 1985 (COBRA). This Act is also known as the Patient Anti-Dumping Act. It imposed a mandatory duty on hospitals to give medical treatment to patients in emergency medical condition and women under labour, failing which the defaulter can be punished under the criminal law. Under that law, a hospital must screen and stabilize such persons and then provide emergency medical treatment. After screening, if the hospital has no facilities, it must transfer the person to another hospital having necessary facilities. In this Report, we have adopted several provisions of EMTALA and made suitable changes to suit our conditions.

We have provided that no hospital or medical practitioner shall refuse to provide emergency medical care to victims of accidents or those in emergency medical condition on the ground that it is a medico-legal case or that the person is not able to pay immediately or that he has no medical insurance or other reimbursement facilities. If they refuse without justifiable reason, that will be an offence.

Hospitals and medical practitioners have to initially screen the persons to decide if the persons require emergency medical treatment. If they do not require such treatment, the further provisions of the Act will not apply. If it is determined that the persons require emergency medical treatment, first they have to be stabilized and thereafter, they must be given treatment. If the hospital or medical practitioner does not have facilities for screening, stabilization or emergency medical treatment, the persons have to be transferred to another hospital or to a medical practitioner having facilities. As to what safeguards have to be taken while making the transfer, as to calling for the services of an ambulance or other vehicle, as to how the persons should be taken care of during transit, all these matters are provided in detail in the Bill annexed to the Report. The hospitals and medical practitioners have to maintain registers as to screening, stabilization, treatment or transfer.

We have also provided that the States must publish a scheme for reimbursement of expenditure incurred by hospitals, medical practitioners or for ambulances and the States must allocate separate funds for this purpose. The duty of the States in this behalf can be traced to Art. 21 as well as to Directive Principles of State Policy enunciated in the Constitution of India.

We have prepared the Report annexing a Model Bill to be enacted by the States as we are aware that the subject of 'hospitals' falls within Entry of State List, Seventh Schedule of the Constitution and, therefore, it will be for the State Legislatures to enact law. The Model Bill, if passed by the States, will also apply to medical practitioners incidentally.

A law to compel hospitals and medical practitioners to attend on victims of accidents those in emergency medical condition and women under labour is one of urgent necessity.

We are sure that upon implementation of the Report and the Bill by the States, the huge gap in the law in this behalf will be legislatively plugged.

Yours sincerely,

(M. Jagannadha Rao)

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## Chapter I

### Introductory

The Law Commission of India has taken up the subject of 'Emergency Medical Care to Victims of Accidents' and other Emergencies' in the light of the observations of the Supreme Court of India in Paramanand Katara vs. Union of India: AIR 1989 SC 2039 and in Paschim Banga Khel Mazdoor Samiti vs. State of West Bengal: 1996(4) SCC 37 regarding the refusal of hospitals to grant emergency relief to patients who are injured in accidents and are in emergency medical condition. There are also certain judgments of the National Consumer Redressal Forum in this behalf.

The Commission is aware of the ground reality that in spite of the observations of the Supreme Court and certain provisions of the Motor Vehicles Act, 1988, it is a fact of life that there is no proper pre-hospital medical care and that private hospitals and medical practitioners who are nearest to the place of accident refuse to admit victims even for emergency medical care, on the plea that the cases are medico-legal cases and they direct the victims to go to government hospitals, howsoever far they may be. Some private hospitals refuse purely on monetary grounds, if the victim is either poor or is not immediately in possession of funds.

The medical literature on the subject states that the 'GOLDEN HOUR' is the first hour immediately after the accident in which 'emergency

medical care' is necessary and most victims die if no such care is available or is not given soon after the accident. The purpose of emergency medical care is to 'stabilize' the patient and this, unfortunately, is not done.

In the public interest case filed in the Supreme Court on the need for emergency care of victims of accident, the Supreme Court of India stated in **Parmand Katra v. Union of India** : AIR 1989 SC 2039 as follows:

“Every injured citizen brought for medical treatment should instantaneously be given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death. There is no legal impediment for a medical professional when he is called upon or requested to attend to an injured person needing his medical assistance immediately. The effort to save the person should be the top priority not only of the medical professional but even of the police or any other citizen who happens to be connected with the matter or who happens to notice such an incident or a situation.”

“Preservation of human life is of paramount importance. That is so on account of the fact that once life is lost, the status quo ante cannot be restored as resurrection is beyond the capacity of man. The patient whether he be an innocent person or be a criminal liable to punishment under the laws of the society, it is the obligation of those who are incharge of the health of the community to preserve life so that the innocent may be protected and the guilty may be punished. Social laws do not contemplate death by negligence to tantamount to legal punishment. A doctor at the Government hospital positioned to

meet the State obligation is, therefore, duty bound to extend medical assistance for preserving life. Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life. No law or State action can intervene to avoid/delay the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way. Every doctor should be reminded of his total obligation and be assured of the position that he does not contravene the law of the land by proceeding to treat the injured victim on his appearance before him either by himself or being carried by others. Zonal regulations and classifications cannot also operate as fetters in the process of discharge of the obligation and irrespective of the fact whether under instructions or rules, the victim has to be sent elsewhere or how the police shall be contacted, the guideline indicated in the 1985 decision of the Committee on Forensic Medicine (set up by the Ministry of Home Affairs of the Government of India) is to become operative.”

“It is expected of the members of the legal profession which is the other honourable profession to honour the persons in the medical profession and see that they are not called to give evidence so long as it is not necessary. It is also expected that where the facts are so clear it is expected that unnecessary harassment of the members of the medical profession either by way of requests for adjournment or by cross examination should be avoided so that the apprehension that the men in the medical profession have which prevents them from discharging their duty to a suffering person who needs their assistance utmost is removed and a citizen needing the assistance of a man in the medical profession receives it.”

In Paramanand Katara v. Union of India 1989 SC 2039, the Supreme Court observed that,

“every injured citizen brought for medical treatment should instantaneously be given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death” .....

“It is further submitted that it is for the Government of India to take necessary and immediate steps to amend various provisions of law which come in the way of government doctors as well as other doctors in private hospitals or public hospitals to attend to the injured/serious persons immediately

without waiting for the police report as completion of police formality. They should be free from fear that they would be unnecessarily harassed or prosecuted for doing their duty without first complying with the police formalities. It is further submitted that a doctor should not feel himself handicapped in extending immediate help in such cases fearing that he would be harassed by the police or dragged to court in such a case. It is submitted that Evidence Act should also be so amended as to provide that the doctor's diary maintained in regular course by him in respect of the accident cases would be accepted by the courts in evidence without insisting the doctors being present to prove the same or subject himself to cross-examination/harassment for long period of time.”

In Paschim Banga Khet Mazdoor Samity v. State of West Bengal, 1996 (4) SCC 37, the Supreme Court further held (para 9) that,

“in this context Shri Dhavan has invited our attention to the recent developments that have taken in this field in the United States. There it was found that private hospitals were turning away uninsured, indigent persons in need or urgent medical care and these patients were often transferred to, or dumped on public hospitals and the resulting delay or denial of treatment had sometimes disastrous consequences. To meet this situation the US Congress has enacted the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) to prevent this practice of dumping of patients by private hospitals. By the said Act all hospitals that receive medicare benefits

and maintain emergency rooms are required to perform two tasks before they may transfer or discharge any individual:

- (i) the hospital must perform a medical screening examination of all prospective patients, regardless of their ability to pay;
- (ii) if the hospital determines that a patient suffers from an emergency condition the law requires the hospital to stabilize that condition and the hospital cannot transfer or discharge an unstabilise patient unless the transfer or discharge is appropriate as defined by the statute.

Provision is made for imposing penalties against hospitals or physicians that negligently violate COBRA. In addition, the individual who suffers personal harm as a direct result of a participating hospital's violation can bring a civil suit for damages against that hospital.”

The Supreme Court further held (para 9) that,

“the Constitution envisages the establishment of a welfare State at the federal level as well as at the State level. In a welfare State the primary duty of the government is to serve the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the government in a welfare State. The government discharges the obligation by running hospitals and health centers which provide medical care to the person

seeking to avail of those facilities. Art. 21 imposes an obligation on the State to safeguard the right to life of every person.”

The Supreme Court referred to the Union of India through an affidavit) in Paramanand Kumar Katara v. Union of India, AIR 1989 SC 2039 (para 6) as follows, namely, that:

“there are no provisions in the Indian Penal code, Criminal Procedure Code, Motor Vehicles Act, etc., which prevent doctors from promptly attending on seriously injured persons and accident cases before the arrival of police and thus taking into cognizance of such cases, preparation of FIR and other formalities by the police. However, the deponent most humbly submits that the respondent shall always abide by the directions and guidelines given by the Hon’ble Court in the present case.”

Though the life and liberty of a person is very much protected under Part III of the Constitution (under Art. 21), and though there is a Supreme Court direction that in all accident cases irrespective of the police complaint, it is the fundamental duty on the part of the hospitals (where the injured were taken) to attend on the patients, unfortunately nothing is done in the matter. As a result, many people have been dying without any care or attention.

Doctors point out that at least 50 per cent of the fatality can be averted if the victims are admitted to a hospital within the first one hour.

For an accident victim, it is important that he is provided basic first aid which enables him to survive till he reaches the hospital.

With increasing vehicle population, there is an ever-increasing number of accidents on our roads. Though our vehicles travel much more slowly compared to global standards, our accident rate per 1000 vehicles is among the highest in the world.

The National Consumer Disputes Redressal Commission in Pravat Kumar Mukherjee vs. Ruby General Hospital & Others (25.4.2005) declared that a hospital is duty bound to accept accident victims and patients who are in critical condition and that it cannot refuse treatment on the ground that the victim is not in a position to pay the fee or meet the expenses or on the ground that there is no close relation of the victim available who can give consent for medical treatment. Sumanta Mukherjee, a 20 year old student was injured when a Calcutta Tramway Corporation bus hit his motorcycle. The victim was taken to the nearest hospital, the Ruby General Hospital. The victim was conscious when he reached the hospital and showed the doctors his medi-claim policy insuring him for Rs. 65,000/-. He assured the hospital that all the bills would be cleared and requested that treatment be given. The doctors started emergency treatment but soon demanded Rs.15,000/- from the persons who brought Mukherjee in. Those persons immediately pooled Rs.2,000/- and informed that they had contacted the parents of the victim and the parents were willing to pay the balance. However, since the amount of Rs.15,000/- was not arranged, the hospitals discontinued treatment. The victim died.

The National Consumer Commission while imposing damages in a sum of Rs.10 lakhs on the Hospital observed that doctors at the hospitals cannot first demand fees before agreeing to treat the patient and they cannot also insist on consent of relatives of the victim before starting emergency treatment. The National Commission relied on Paramanand Katara decided by the Supreme Court, referred to above. It held that the preservation of human life is of paramount importance. That is also in consonance with the Code of Medical Ethics. Recovery of fees can wait, but treatment cannot be denied.

The Supreme Court in Indian Medical Association vs. V.S.Shanta:1995(6) SCC. 651 observed that a hospital has generally two categories of patients, those who pay and those who are treated free, the free patients acquire the status of consumers because it is deemed that the treatment to free patients is deemed to be met by the paying patients.

In view of the above judgments of the Supreme Court and the National Consumer Redressal Forum and the fact that there is no appropriate legislation on the subject, the Law Commission of India has taken up the subject suo motu. It proposes to give recommendations and also a draft Model Bill for the purpose of emergency treatment of victims. The Bill will cover medical treatment to victims of all types of emergencies requiring immediate medical help, including motor, fire and other accidents, which take place during earthquakes, floods, etc. It can also be in respect of a woman under labour.

## **Chapter II**

### **Current state of emergency medical care and laws in India**

Accidents where victims require emergency medical care are not confined to motor accidents. Emergencies may arise due to motor accidents, fire, floods, cyclone, earthquakes etc. or even sudden collapse of victims or emergent deliveries in pregnancy.

Among these, road accidents, however, contribute the largest number of deaths or injuries. These accidents are increasing at an alarming rate of 3% annually. About 10.1% of all deaths in India are due to accidents and injuries. A vehicular accident is reported every 3 minutes and a death, every 10 minutes on our records. During 1998, nearly, 80,000 lives were lost and 330,000 people were injured. Of these, 78% were persons in the age group of 20-44 years. A trauma-related death occurs in India every 1.9 minutes. The majority of road accident victims are pedestrians, two wheeler riders and bicyclists, passengers by motor vehicles, as cited in the paper (2006) submitted by Ms. Shradd Deshmukh, ILS, Law College, Pune on 'Emergency Medical Aid to Victims', to the Law Commission.

The World Report on Road Traffic Injury Prevention released by the WHO on World Health Day (7<sup>th</sup> April, 2004) stated that around 12 lakh people die each year on account of accidents globally.

In the year 2004, the National Human Rights Commission constituted an Expert Group to study the existing system for emergency medical care in

India to suggest appropriate methods of emergency medical care, which should be developed by different States/Union-Territories and their essential components. The Group submitted a Report on 7<sup>th</sup> April 2004. It reviewed the existing scenario and the Centralised Accident and Trauma Services (ATS) and stated that nearly 4 lakh persons lose their lives annually due to injuries, nearly 75 lakh persons are hospitalized and three and half lakh persons who receive minor injuries get emergency care at various places in India. However, present Emergency Medical Support (EMS) in the country is functioning sub-optimally and requires upgradation. The Report revealed the lacunae, which exist in the present EMS and made a number of recommendations for implementation in the short term and in the long-run. These recommendations were sent to the Health Services and the States and UTs. (Medical Relief to Road Accident Victims submitted by Devanshi Nijhara, ILS Law College Pune, to the Law Commission). Text of full Report of NHRC titled “Emergency Medical Services in India – Present Status and Recommendations for Improvement” is published in ‘Journal of the National Human Rights Commission’ vol.3, 2004.

Government of India has accorded permission for the establishment of 100 Emergency Accident Relief Centres in all the National Highways/State Highways at a distance of 50 km each to give timely first aid to accident victims and to arrange for further medical treatment in hospitals. This is a unique programme implemented by the Government jointly with private hospitals, sponsors etc. Out of the 100 centres targeted, 77 are now functioning. Among the centres now functioning, 41 are fully financed by private hospitals and institutions while the remaining 36 are partly sponsored by the Government and provide a monthly support of

Rs.40,000/- or the actual expenditure incurred by these sponsors (not exceeding Rs. 40,000/- . During the year 2004, with timely medical aid, these centres are said to have saved 19,595 lives, treated 6,400 serious injured cases and 13,195 persons with minor injuries. (ibid, Devanshi Nijhara's Paper).

The Indian Emergency Journal (Aug., 2005) in its Editorial says:

“The fact is that 80,000 people are killed in accidents every year .... At least 30 to 45 minutes elapse between the time of a crash and arrival at hospital. 12 percent of institutions in the trauma-care-sector have no access to ambulance. Only 50 per cent of the available ambulance services possess the acute-care facilities needed to keep an accident victim alive during transportation... And only 4 per cent of personal staffing these services (have certified formal training).

**National Toll Free Number 108 and Ambulances & Identifying Hospitals:** (Hindu dated 4<sup>th</sup> July 2006, p.12)

“Ambulances with state of art equipment would, it is stated, be deployed by the National Highways Authority of India (NHAI) for every 50 km on completed stretches of highways entrusted to them.

A national toll-free telephone number 108, will be earmarked (it has already been done in Andhra Pradesh) to which information on accidents can be passed on, immediately by passengers or passersby. This was decided at a meeting to draw a road map to develop an integrated and

comprehensive system of trauma care by the Ministry of Road Transport and Highways and the Ministry of Health and Family Welfare.

The Department of Economic Affairs of the Union Finance Ministry and the Department of Road Transport and Highways will jointly devise an insurance-funded payment for the treatment of victims of hit and run accidents.

Under the scheme, the Health and Family Welfare Ministry will identify distinct Government Hospitals near the National Highways, for a time-bound upgradation of trauma care facilities. They would also standardize the configuration of ambulances with the latest equipment and draw up qualification for the staff to be deployed on them. This is to ensure that staff would be able to stabilize the condition of victims prior to hospitalization.

The meeting was attended by senior officers of the Department of Road Transport and Highways, National Highways Authority of India, Ministry of Health and Family Welfare, Department of Economic Affairs, (Insurance Division) and Ministry of Telecommunication.

The other decisions include gradual extension of deployment of ambulances to national highways under construction, provision of ambulances to States, NGOs.”

Tamil Nadu State : Road Safety Council, Road Safety Fund & Identification of hospitals on Highways

In Tamil Nadu, Government has established under section 215 of the Motor Vehicles Act, 1988 and appointed a Road Safety Commissioner who has various duties including accident relief.

A Road Safety Fund has been created during the year 2000 to fund Road Safety Activation. Allocations will be made to the fund from compounding fees and spot fines collected by Transport and Police Departments. The fund will be administered by a committee chaired by the Home Secretary.

The Highway Patrol force is proposed to be re-organised by integrating it with traffic accident posts and linking with Emergency Accident Relief Centres (EARC). 80 stretches have been identified for Highway Patrol with 160 teams by the Police Department and a concurrent team to co-ordinate with the Highway Patrol Team.

The Tamil Nadu Government has identified Emergency Relief Centres (ARCs) on mega highways in Tamil Nadu and has proposed such centres for every 50 Kms on the National Highways in the State. These Centres can be contacted by dialing the toll free number 1033 from any landline phone near accident spot. A fully equipped ambulance with a trained paramedic is always on standby to respond to such calls. Victims are transported to the nearest hospitals free of charge.

A large number of hospitals, about 75 have been identified (see <http://www.tn.gov.in/sta/roads.htm>) and 7 more are proposed.

The Basic feature of the scheme is to establish 100 emergency ARCs on National Highways/State highways throughout Tamil Nadu. These centers are operated by leading hospitals in the area. It is an example of public-private partnership model. The starting infrastructure like cubicle, ambulance, etc., is provided by the sponsoring agency/hospital. The local Regional Transport offices help in getting telephone and water/Electricity connections. Some Centres are fully sponsored where the full maintenance cost including salary, fuel, medicine etc. are borne by the sponsoring hospitals.

Some Centres are sponsored where the staff is provided by the hospitals and maintenance expenditure is given by the State Government. To establish any new Centre, preference is given to full sponsorship. In case there is no sponsor ready to take the full expenditure, Government will provide the maintenance expenditure. As on 27.1.2004, there are 75 Centres functioning and 25 more Centres are proposed. It is stated that as on 1.9.2004, 16,326 lives have been saved.

Andhra Pradesh : Satyam EMRI : Toll Free No.108 and Ambulances:

Satyam group who are leaders in computer technology have set up the Emergency Management Research Institute (EMRI), a non-profit society, for round-the clock emergency response service.

The Andhra Pradesh Government in conjunction with Ministry of Communication, Government of India, has allocated the free toll telephone number 108 (on the model of 911 in USA). 108 will be uniform across the country. The Hyderabad EMRI Institute's primary objective is to aid the

needy in emergencies like Medical, Fire, Accident, etc. by providing timely attention and support.

The Project was structured to be carried out in phases, to facilitate a planned rollout of emergency services across the State of Andhra Pradesh. To start with, the cities of Hyderabad, Secunderabad, Vishakhapatnam, Tirupathi, Vijayawada and Warangal have these ambulances. This scheme is stated to be the first of its kind in India.

In the second phase, the scheme will cover most of the towns in Andhra Pradesh.

Technical challenges include:

System Integration of disparate system of multiple vendors.

Integrating EMRI applications with NORTEL.

It was decided to go ahead with closed Applications Call system and Contractclosed Dispatching System, to be implemented in the first phase and co-ordinating it into a Distributor Call –Taking and Distributor Dispatching System in latter phases, covering the entire State.

The system integrator, which is a company known as GTL, has studied the business challenges and delivered the following solutions:

- (1) All calls for emergency (Hyderabad and other ... locations) will land in Communication Server 1000 M at Hyderabad Call Centre through BSNL Network.

- (2) Communication Server 1000 M and Symposium Call Centre Server will route the call to the respective available Agent/Call taker at Hyderabad.
- (3) The Call Despatcher, located at Hyderabad shall dispatch the calls for respective regions using PSTN/Wireless Network.
- (4) The agent will be able to transfer or conference a live-call with a call despatcher.

The Emergency Response Vehicles are fitted with GPS system for mapping and tracking. EMRI had signed a memorandum of understanding with the Andhra Pradesh Government for a public-private partnership initiative.

A Journal called, India Emergency Journal, (a quarterly) was also released.

There is a proposal to set up an Indian Emergency Management Authority (IEMA) at the national level to enable State Governments to operate emergency response centers for promoting and enhancing public safety by providing legal, financial and administrative policy framework.

It is stated that the call centre on Medchal Road (Byrraju Foundation) is receiving on an average 2,200 calls per day from various parts of the twin cities. During the first 45 days, they received more than 1,00,600 calls and they saved 375 lives. Two-thirds of calls were accident related.

Presently, 40 responders work in three shifts at the call centres.

30 Ambulances and an equal number of responders (on two-wheelers) are stationed at vantage points throughout the city.

The EMRI Ambulances are equipped with automated external defibrillator with multi-para monitors, oxygen manifold system and 'Bord Avion' ventilators.

They are equipped with extricate tools, fire extinguishers and rescue blankets to help the victim.

#### Current Legal Framework:

So far as current legal framework is concerned, in spite of the fact that rash and negligent driving of a motor vehicle falls within the scope of sec. 304-A of the Indian Penal Code, 1860 where imprisonment may go upto 2 years accidents due to negligent driving of motor vehicles have not stopped. Of course if it amounts to culpable homicide or murder under section 299 read with section 300, the punishment under sections 302 or 304 may extend to life imprisonment or 10 years.

Initially, in 1978, a Bill was introduced in the Rajya Sabha and was passed on 23.2.1978 which referred to amendment of section 304-A. It not only recommended increase in punishment from 2 years to 5 years, it proposed a new section 304B for drivers who runaway without informing police within a reasonable time, that the punishment must be 7 years imprisonment.

This Bill was not passed by the then Lok Sabha on account of its dissolution.

Later, the Bill was referred to the Law Commission and in the 156<sup>th</sup> Report the above amendments were reiterated. So far as section 304B is concerned, because another section with that number had already been inserted, the Commission recommended a change in the number as section 304B.

The Motor Vehicle Act, 1988 contains a whole chapter on “Accident Compensation” which includes a provision for no fault liability, currently fixed at Rs.50,000/- if death is caused or Rs.25,000/- if it causes injury. This is intended to help tide over immediate financial problems. There is, of course, provision for compensation for negligently killing or injuring any person. There is vast legal literature as to the manner of computing compensation. Under an ‘Act-policy’ provision contained in the said Act, Insurance Companies which issue policies have to cover certain mandatory risks. Lok Adalats and Motor Accident Claim Tribunals, all over the country provide remedies for payment of compensation for death or injury.

In the 178<sup>th</sup> Report of the Law Commission (2001), a lacuna in the law pointed by the High Courts in several judgments was sought to be remedied. But Parliament has not yet implemented the same recommendation. We propose to reiterate that amendment. The problem is that if a person who is injured and has claimed compensation dies as a consequence of the injury, while the claim is pending before the Claims Tribunal, the proceedings abate and the deceased’s estate represented by his

legal representatives get nothing. The benefit of the abatement goes to the tort-feasor. This is happening in a number of cases. The Law Commission has, therefore, recommended an amendment which allows the proceedings to be continued by the legal heirs of the injured person who has died during the pendency of the litigation.

So far as 'emergency medical aid' is concerned, we have referred to the judgment of the Supreme Court in Parmanend Katara and other cases decided by the National Consumer Redressal Forum. Apart from these, there are some special provisions introduced into the Motor Vehicle Act, 1988.

Section 134 of the Motor Vehicles Act, 1988 imposes a duty on the driver of the vehicle and of the doctor and hospital who are approached. Section 187 creates an offence if sec 134 is not complied with. Section 134 reads as follows:

"Section 134: Duty of Driver in case of accident and injury to a person:

When any person is injured or any property of a third party is damaged as a result of an accident in which a motor vehicle is involved, the driver of the vehicle or other person in charge of the vehicle –

- (a) unless it is not practicable to do so on account of mob fury or any other reason beyond his control, to take all reasonable steps to secure medical attention for the injured person, by conveying him to the nearest medical practitioner or hospital, and it shall

be duty of every registered medical practitioner or the doctor on duty in the hospital immediately to attend to the injured person and render medical aid or treatment without waiting for any procedural formalities, unless the injured person or his guardian, in case he is a minor, desires otherwise;

- (b) give on demand by a police officer, any information required by him or, if no police officer is present, report the circumstances of the occurrence, including the circumstances, if any, for not taking reasonable steps to secure medical attention as required under clause (a) at the nearest police station as soon as possible, and in any case within twenty-four hours of the occurrence ;
- (c) give the following information in writing to the insurer, who has issued the certificates of insurance, about the occurrence of the accident, namely:-
  - (i) Insurance policy number and period of its validity;
  - (ii) Date, time and place of accident;
  - (iii) Particulars of the persons injured or killed in the accident;
  - (iv) Name of the driver and the particulars of driving licence.

Explanation: For the purposes of this section, the expression “driver” includes the owner of the vehicle.”

Under section 187 of the said Act, whoever fails to comply with the provisions of the various clauses of section 134, shall be punishable with imprisonment for a term which may extend to three months, or with which may extent to Rs.500/- or with both. If it is a second time such an offence is

committed by a person, the punishment by imprisonment may extend to six months or with fine which may extend up Rs. 1000/- or with both.

But, in a large number of cases, which are known as the 'hit and run' cases, the driver who runs away under cover of darkness or when he speeds up and runs away or when there is nobody in the vicinity to note down the number of the vehicle, or where the injured person not being in a fit condition to note the number, the unfortunate position is that the driver or the vehicle number is not traceable. In such situations, the above provisions of sec 134 or 187 of the Motor Vehicles Act, 1988 are not helpful. The serious apathy of the runaway tort teaser cannot be easily remedied.

Further, the above provisions of the Motor Vehicles Act do not cover accidents due to other transport vehicles, like carts, cycle rickshaw, etc. Nor does it cover victims of fire, flood, etc.

In addition, passers by who witness the accident fear harassment by police and are not willing to take the victim to a hospital or report to the police. They do not want to be called to the police station or to the Court for their statements or evidence to be recorded.

#### Pre-hospital Care: Equipped Ambulances and transport

The British Medical Journal noted in one of its reviews on 'trauma' issues that society seems to accept a lower standard of safety for road users than for other modes of transport. In India, the problem is more acute due to shortage of trained surgeons to handle accident trauma, poor diagnostic

infrastructure in government hospitals and because of grossly insufficient ambulance services in rural and semi-urban areas. Trained personnel staffing professional ambulance services will make a world of difference. The British Journal states that for accident victims, the golden hour is a continuous process beginning with the care that is given in the ambulance en route to hospital; this protection is vital for survival rates.

Dr. P.V. Jayashankaran and Dr. P.C. Raja Ravi Verma, in an article in the 'Hindu' magazine section (dated Oct. 16, 2005) have, after giving statistics about accidents globally, and in India and Tamil Nadu state are as follows:

“.... the chances of survival are bleak as we truly lack an awareness of the most important service, the pre-hospital care’.

‘..... any tragic accident can be construed to be a success or failure within the first 10 minutes of medical attention as this is the time when the most important decisions are to be taken. It is here that the concept of the Golden Hour comes into play. The concept can be better understood if one were to learn the primary (Trimodal) causes of death in major accidents. In fact, the London blasts highlighted the case of an explosion in a double-decker bus that went off near a conference hall hosting a meeting of medical practitioners. The prompt medical care made available by the various specialists is a case in point.’

About the pre-hospital facilities available in UK, the authors say that in the United Kingdom the support systems are quite effective. The National Health Services has well-equipped ambulances with top class personnel (para-medicals) to manage accident victims throughout the country under a single umbrella. These ambulances rush to the spot and effectively avert any tragedy within the early minutes by way of proper assessment of the injuries and they quickly transport the victims to the nearest hospitals. By the time the victim reaches the hospital, he or she is almost saved and it becomes easy for starting definitive treatment.

In India, according to the above authors, the situation is different. Whenever an accident occurs, the focus on saving the life of the victims gets diluted due to the fear of subsequent legal procedures and due to paucity of people with an awareness of the importance of pre-hospital care. What is required is a well maintained, state-of-the-art ambulance with oxygen, intravenous infusions, life-saving drugs, splints, defibrillators and ventilators. Well trained para-medical staff must be available at all times in the ambulance.

The government has formed a number of Emergency Accident Relief Centres (ARCD) through which the ambulances are sent to the scene of accident but there is dearth of qualified para-medical personnel who can assess or assist a victim. 32 Centralised Accident Trauma Services (CATS) ambulances, says a Delhi Report (Express Newslines, Aug. 25, 2005) were imported from Japan in the year 2000 at a cost of Rs.17.50 lakhs each and of them, only 18 are functional. Compared to the early Omni-vans and Gypsies that were used as ambulances, the CATS Ambulances are more

spacious and have medical facilities fitted inside the ambulances. The advanced equipment in big vans, says a paramedical, were previously not available in the Omni Vans or Gypsies. In case there is a serious road accident, if the ambulance is not well equipped and if paramedical personnel are not available in the ambulance, the transport facility does not qualify for being recognized as a pre-hospital care facility.

His Excellency the President of India Shri A.P.J. Abdul Kalam in his inaugurated address at the Annual General Meeting of the Indian Red Cross Society and St. John Ambulance, New Delhi on October 17, 2004 strongly pleaded for an integrated and institutionalized approach for emergency response. He suggested a scheme, in which whenever an accident occurs, a message could be sent to the nearest ambulance team and immediate medical help is arranged for. He also recommended for formulating a legal mechanism for providing such emergency support in critical situations. He disapproved the tendency among people to avoid coming to the succour of accident victims, fearing medico-legal issues. He said that hospitals demanding the presence of the police and the completion of formalities before they could start treating the patients are undesirable (see an article Challenges of Emergency Management in India by Anil K. Sampada, published in Indian Emergency Journal, vol.1).

As of now in India, there is no proper legal framework to (1) encourage citizens to report and come out to give help to the accident victims without fear of harassment, (ii) to mandate all doctors and hospitals to attend accident victims and provide all medical facilities for stabilizing patients in emergency, (iii) establish trained paramedics for pre hospital care

during transport (iv) to aid and implement trauma care system regardless of jurisdictional boundaries.

In the light of the number of accidents in the country, the indifference of those who witness an accident in offering prompt assistance on account of the likelihood of facing to comply with legal formalities, lack of ambulances with well equipped medical facilities or para-medical staff, it is clear that the situation needs to be remedied by corrective action. We are proposing draft legislation as a step in this direction.

It is first necessary to certain laws relating to emergency medical care in other jurisdictions.

### CHAPTER III

#### **Emergency Medical Care procedures in Hospitals other Jurisdictions:**

In the chapter-II, we had occasion to refer briefly to the facilities available in the United Kingdom and also to the Centralized Accident Trauma Services (CATS) introduced in a small measure in certain places in India. But, it is necessary to refer to the emergency accident-care procedures in other jurisdictions in some more detail.

#### **U.S.A.:**

##### **Protection to those who render emergency care of injured:**

In the State of Virginia, the Code of Virginia (as amended in 2000) contains sec. 8.01.225 which exempts a person from civil liability when he renders emergency care or assistance. The section provides that any person who, in good faith, renders emergency care or assistance without compensation, to any person who is ill or injured at the scene of the accident, fire or life threatening emergency, or en route therefrom to any hospital, medical clinic or doctor's office, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such care or assistance. Similarly, if any person provides assistance upon request of any police agency, fire department, rescue or emergency squad, or any governmental agency in the event of an accident or other emergency, he shall not be liable for any civil damages resulting from any act, omission on his part in the course of rendering such assistance in good faith.

In New York, a similar provision exists in Art 30 of the Public Health Law Emergency Medical Services. Section 300A provides that any person who voluntarily and without expectation of any monetary compensation renders first aid or treatment at the scene of an accident or other emergency, outside a hospital or to a person who is unconscious, ill or injured, shall not be liable for damages for injuries alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason on an action, omission in the rendering of such emergency treatment.

EMTALA (USA): (Anti-dumping law): Duties of hospitals:

The Emergency Medical Treatment and Labor Act, 1986 (EMTALA) is a federal law enacted by Congress as part of the Consolidated Omnibus Budget Reconciliation Act, 1985 (COBRA) (42 USC sec 1395 dd), referred to by the Supreme Court in Paschim Banga Khet Mazdoor Samiti case 1996 (4) SCC 37.

The above Act is also known as the “anti-dumping” law, as it was designed to prevent hospitals from refusing to treat patients or transferring them to charity or public hospitals because the victims are unable to pay or had Medic-aid coverage. EMTALA requires hospitals with emergency departments to provide emergency medical care to everyone who needs it, regardless of ability to pay or insurance status. Under the law, the patients with similar medical conditions must be treated consistently. The law applies to hospitals that accept Medicare reimbursement and to all their patients, not just those covered by Medicare.

The Guide for Interfacility Patient Transfer published by the National Highway Traffic Safety Authority, USA (April, 2006) (NHSTA) gives a lot of details about the Act and various other particulars. (see [www.nhtsa.dot.gov.gov/partal/site/nhtoc/menuitem](http://www.nhtsa.dot.gov.gov/partal/site/nhtoc/menuitem)).

Under EMTALA (extracted in this chapter), the hospitals have these basic obligations:-

- (1) The hospitals must provide all patients with a medical screening examination to determine whether an emergency medical condition exists without regard for ability to pay for services.
- (2) Where an emergency medical condition exists, they must either provide treatment until the patient is stabilized, or if they do not have the capabilities, transfer the patient to another hospital.
- (3) Hospitals with specialized capabilities are obliged to accept transfers if they have the capabilities to treat them. Medical care cannot be delayed by questions about methods of payment or insurance coverage.

Of course, under (1) if an appropriate medical screening examination identifies that no emergency medical condition exists, the EMTALA obligation ceases to exist. Under (2), no EMTALA obligation exists if an identified medical condition is stabilized. Additionally, latest regulations now recognize that a patient with an emergency medical condition may be discharged with a plan to have subsequent treatment provided as an outpatient if such a plan is consistent with medical routine and does not jeopardize the patient's health.

The NHTSA Guide further states that EMTALA governs how patients may be transferred from one hospital to another. Under the law, a patient is considered stable for transfer if the treating physician determines that no material deterioration will occur during the movement between facilities and that the receiving facility has the capability to manage the patients' medical condition. EMTALA does not control the transfer of a stable patient; however, patients with incompletely stabilized emergency medical condition may still be transferred under EMTALA if one of the two following conditions exists:

- (a) the patient (or someone acting on the patients' behalf) provides a written request for transfer despite being informed of the hospitals' EMTALA obligations to provide treatment; or
- (b) a physician certifies that medical benefits reasonably expected from transfer outweigh the risk to the individual.

Once a doctor has decided to transfer the individual, (points out the Guide), the following steps must be taken:

- (i) the transferring hospital must provide all medical treatment within its capacity, which minimizes the risk to the individual's health.
- (ii) the receiving facility must accept the transfer and must have space available and qualified personnel to treat the individual.
- (iii) the transferring hospital must send copies of all medical records related to the emergency medical condition. If the physician on call refuses or fails to assist in the

patient's case, the physician's name and address must be documented on the medical records provided to the receiving facility.

- (iv) Qualified personnel, with the appropriate medical equipment, must accompany the patient during transfer. The transferring physician, by law, has the responsibility of selecting the most appropriate means of transport to include qualified personnel and transport equipment.

Under EMTALA, the patient care during transport is the responsibility of the transferring physician/hospital until the patient arrives at the receiving facility. The transferring physician is also responsible for the orders as to transfer and for the treatment orders to be followed during the transport. This may conflict with (US) State statutes, which in some instances, allow only authorized medical physicians to give orders to EMS personnel. EMTALA does not refer to the transport service and its medical directive, leaving ultimate medical responsibility and its transition during transport open for interpretation.

Certificate of necessity for transfer is a requirement for reimbursement by the Centres for Medicare and Medic-aid Services (CMS). The CMS definition of 'medical necessity' is as follows:

'Medical necessity is established when the patient's condition is such that use of any other method of transportation is contra-indicated. In any case, in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.'

Regulations:

The Centers for Medicare and Medicaid Services has issued Regulations pertaining to the enforcement of this law. Regulations go into much greater details than the statute. Proposed rules published in 1988 can be found in the federal Register (June 16, 1988) (53 FR 22513). In the EMTALA, obligations are tied to hospitals' participation in Medicare. In fact, a hospital could relieve itself of EMTALA obligations by dropping out of the Medicare program; although this certainly would not be financially beneficial to the hospital (Guide for inter-facility patient transfer, April 2006, NHTSA, Appendix D, E).

EMTALA STATUTE: (Emergency Medical Treatment and Labor Act)

**EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL  
CONDITIONS AND WOMEN IN LABOR**

(42 U.S.C. § 1395dd)

“Sec. 1867. (a) MEDICAL SCREENING REQUIREMENT – In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1))

exists.

(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND LABOR

1) IN GENERAL – If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either –

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) REFUSAL TO CONSENT TO TREATMENT – A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) REFUSAL TO CONSENT TO TRANSFER – A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual’s behalf) of the risks and benefits to the individual of such transfer, but the individual (or person acting on the individual’s behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual’s (or person’s) written informed consent to refuse such transfer.

(c) RESTRICTING TRANSFERS UNTIL INDIVIDUAL STABILIZED –

(1) RULE – If an individual at a hospital has an emergency medical condition which has not stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless –

(A)(i) the individual (or a legally responsible person acting on the individual’s behalf) after being informed of the hospital’s obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1861 (r)(1)) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the

increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861 (r)(1)), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) APPROPRIATE TRANSFER – An appropriate transfer to a medical facility is a transfer –

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual’s health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility -

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) who was refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) ENFORCEMENT –

(1) CIVIL MONETARY PENALTIES –

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than \$50,000 (or not more than \$25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who –

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than \$50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this title and State health care programs. The provisions of section 1128A (other than the first and second sentences of subsection (a) and subsection (b)) shall

apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a).

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I)) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

## (2) CIVIL ENFORCEMENT –

(A) PERSONAL HARM – Any individual who suffers personal harm as a direct result of a participating hospital’s violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY – Any medical facility that suffers a financial loss as a direct result of a participating hospital’s violation of a requirement of this section may, in a civil action

against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) LIMITATIONS ON ACTIONS – No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) CONSULTATION WITH PEER REVIEW ORGANIZATIONS – In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(e) DEFINITIONS – In this section:

(1) The term “emergency medical condition” means –

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment of bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions –

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term “participating hospital” means hospital that has entered into a provider agreement under section 1866.

(3)(A) The term “stabilize” means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term “stabilized” means with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term “transfer” means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated directly or indirectly with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term “hospital” includes a rural primary care hospital (as defined in section 1861(mm)(1)).

(f) **PREEMPTION** – The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with the requirement of this section.

(g) **NONDISCRIMINATION** – A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized

capabilities or facilities if the hospital has the capacity to treat the individual.

(h) NO DELAY IN EXAMINATION OR TREATMENT – A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual’s method of payment or insurance status.

(i) WHISTLE BLOWER PROTECTIONS – A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.”

#### EMTALA REGULATIONS

“Regulation 489.24: Special responsibilities of Medicare hospitals in emergency cases

- (a): “General: In the case of a hospital that has an emergency department, if any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him or herself or with another person to the emergency department and a request is made on the individual’s behalf for examination or treatment of a medical condition by qualified medical personnel (as determined by the hospital in its rules

and regulations), the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examinations must be conducted by individuals determining qualified by hospital by law or rules or regulations and who meet the requirements of sec. 482.55 concerning emergency services personnel and direction.”

(b) We shall refer to some definitions in the Regulation

(A) ‘Comes to the emergency department’ means, with respect to an individual requesting examination or treatment, that the individual is on hospital property. For purposes of this section, ‘property’ means the entire main hospital campus, including the parking lot, sidewalk and drive way, as well as any facility or organization that is located off the main hospital campus but has been determined to be a department of the hospital. ‘Property’ also includes ambulances, owned and operated by the hospital even if the ambulance is not on hospital grounds. An individual in a non-hospital owned ambulance on hospital property is considered to have come to the hospital's emergency department even if a member of the ambulance staff contacts the hospital on telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for

examination and treatment. In these situations, the hospital may deny access if it is ‘discretionary status’, that is, it does not have staff or facilities to accept any additional patients. If, however, the ambulance disregards the hospital’s instructions and transports the individual on to the hospital property, the individual is considered to have come to the emergency department.

(B) The regulations define ‘Capacity’ of a hospital as being its ability to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as number and availability of quality staff, beds and equipment on the hospital’s past practices of accommodating additional patient in excess of its occupancy limits.

(C) ‘Emergency Medical Condition’ means (1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in –

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contraindications –

- (a) that there is inadequate time to effect a safe transfer to another hospital before delivery or
  - (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.
- (D) ‘Stabilized’ means with respect to an ‘emergency medical condition’ as defined in this section means:
- (i) that no material deterioration is likely, within reasonable medical probability, to result from or occurs during the transfer of the individual from a facility or with respect to an ‘emergency medical condition’.
  - (ii) that the woman has delivered the child and the placenta.
- (E) ‘To stabilize’ means, with respect to an ‘emergency medical condition’:
- (i) to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occurs during the transfer of the individual from a facility; or
  - (ii) with respect to an ‘emergency medical condition’, the woman has delivered the child and the placenta.

Regulation 489.24 (Special responsibility of Medicare hospitals in emergency cases):

Section (c) “Necessary stabilized treatment for emerging medical conditions:

- (1) If any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines

that the individual has an emergency medical condition, the hospital must provide either –

- (i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition; or
- (ii) for transfer of the individual to another medical facility in accordance with para (d) (below) of this section.”

(2) Refusal (by victim) to consent to treatment: This provision states that after the hospital with an emergency department informs the patient or person acting on his behalf, of the risks and benefits to the individual of the examination and treatment, but the individual (or person acting on his behalf) refuses consent to the examination and treatment, the medical record of the hospital must record the refusal and take all reasonable steps to secure the individual’s written informed consent (or that of the person acting on his or her behalf). The written document must indicate that the person has been informed of the risks and benefits of the examination or treatment.

“(3) Delay in examination or treatment (not permissible): A particular hospital (i.e. that has entered into a Medicare provider agreement under section 18.66 of the Act) may not delay providing an appropriate medical screening examination or further medical examination and treatment

required in order to inquire about the individual's method of payment or insurance status.

(4) This clause deals with refusal by the victim or the person acting on his behalf, for transfer to another medical facility having required facilities. Written refusal must be obtained.”

Section (d) Restricting transfer until the individual is stabilized:

(1) If an individual at a hospital has an emergency medical condition that has not been stabilized, the hospital may not transfer the individual unless –

(i) the transfer is an appropriate transfer as stated in section (d)(2), and

(ii) (A) the individual (or a legally responsible person acting on his behalf) requests the transfer, after being informed of the hospital's obligation under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer.

(B) a physician has signed a certificate that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labour, to the woman or the unborn child, from being transferred.

The certification must contain a summary of the risk and benefits upon which it is based; or

(C) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its by laws and regulations) has signed a certificate described in clause B above after a physician in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certificate. The certificate must contain a summary of the risks and benefits upon which it is based.

- (2) A transfer to another medical facility will be appropriate only in those cases in which –
- (i) the transferring hospital provides medical treatment within its capacity that minimizes the risk to the individual's health and, in the case of a woman in labour, the health of the unborn child;
  - (ii) The receiving facility –
    - (A) has available space and qualified personnel for the treatment of the individual; and
    - (B) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

- (iii) the transferring hospital sends to the receiving facility, all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of transfer) including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under this section, and the name and address of any on-call physician who has refused or failed to appear within reasonable time to provide necessary stabilizing treatment. Other records (e.g. test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer, and
  - (iv) the transfer is effected through qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures during the transfer.
- (3) a participatory hospital may not initiate do take adverse action against a physician or a qualified medical person described in para d(1)(ii)(C) above because the physician

or qualified person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

Sub-section (e): Recipient hospital's responsibilities:

A particular hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with regard to rural areas) regional referral centres) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

Section (f): Termination of provider agreement: If a hospital fails to meet the requirement of section (a) to (e), the HCFA may terminate the 'provider agreement' in accordance with section 489.53.

....

Section (h): Off Campus Departments: If an individual comes to a facility or organization that is located off the main hospital campus but has been determined to be a department of the hospital and a request is made on the individual's behalf for examination or treatment of a potential emergency medical condition as

otherwise described in section (a), the hospital is obligated, in accordance with the rules, to provide the individual with an appropriate medical screening examination and any necessary stabilizing treatment or an appropriate transfer.

(1) Capability of the hospital:

The capability of the hospital includes that of the hospital as a whole, not just the capability of the off-campus department. Except for cases described in para (i)(3)(ii), the obligation of a hospital under this section must be discharged within the hospital as a whole. However, the hospital is not required to locate additional personnel or staff to off-campus departments to be on standby for possible emergencies.

(2) Protocols for off-campus departments

....

(3) Movement or appropriate transfer from off-campus departments

.. .. .. .. ..”

EMTALA Sign requirement at Hospitals:

The following NOTICE TO THE PUBLIC is required to be displayed in all public entrances, registration areas, emergency department, waiting areas of Hospitals, as required by the HCFA (Health Care Financing Administration) of U.S.:-

“IT’S THE LAW

IF YOU HAVE A MEDICAL EMERGENCY, OR, ARE IN LABOUR YOU HAVE THE RIGHT TO RECEIVE, (within the capabilities of this hospital’s staff and facilities)

AN APPROPRIATE MEDICAL SCREENING EXAMINATION  
NECESSARY STABILIZING TREATMENT (including treatment  
for an unborn child) and, if necessary, AN APPROPRIATE  
TRANSFER to another FACILITY EVEN IF YOU CANNOT PAY  
OR DO NOT HAVE MEDICAL INSURANCE or  
EVEN IF YOU ARE NOT ENTITLED TO MEDICARE OR  
MEDICAID. THIS HOSPITAL DOES/DOES NOT PARTICIPATE  
IN THE MEDICAID PROGRAM.”

The above sign must be visible from a distance of 20’ away or from  
patient’s likely viewing point and posted in a manner likely to be seen.

These provisions of EMTALA and the Regulations made for the  
purpose of enforcing EMTALA can be a model for considering appropriate  
reconsideration for a law in our country.

## CHAPTER IV

### Ambulance Services in other Jurisdiction

In order to give an idea of regulation of ambulance services, we shall refer to the rules in force in USA, for example in the State of Minnesota (we are not covering these aspects relating to ambulances in the Bill attached to this Report).

#### USA – Ambulance Services:

The State of Minnesota in USA in city statutes of 2004 deals with Ambulance Services. In section 144 E(1) to 144 E(52) there are several provisions which can be a model for legislation in India. We do not propose to refer to all the provisions except the crucial ones.

So far as definitions are concerned, we shall refer to a few of them which are important:

001(1b) defines ‘**Advanced life support**’ as means ‘rendering basic life support and rendering intravenous therapy, drug therapy, intubation, and defibrillation’.

001(2) defines ‘**Ambulance**’ as means ‘any vehicle designed or intended for and actually used in providing ambulance service to ill or injured persons or expectant mothers.’

001(3) ‘**Ambulance service**’ means transportation and treatment which is rendered or offered to be rendered preliminary to or during

transportation to, from, or between health care facilities for ill or injured persons or expectant mothers. The term includes all transportation involving the use of a stretcher, unless the person to be transported is not likely to require medical treatment during the course of transport.

001.3a: **Ambulance service personnel** means individuals who are authorized by a licensed ambulance service to provide emergency care for the ambulance service and are:

- (1) Emergency Medical Technicians, Emergency Medical Technician-Intermediate, or Emergency Medical Technician-Paramedic;
  
- (2) Registered nurses who are qualified ...
  
- (3) Registered physician assistants ...

001.4a: **Basic airway management** means:

- (i) resuscitation by mouth-to-mouth, mouth-to-mask, bag valve mask, or oxygen powered ventilators; or

- (ii) insertion of an oro-pharyngeal, nasal pharyngeal, esophageal obturator airway, esophageal tracheal airway, or esophageal gastric tube airway.

001.4b: **Basic life support** means rendering basic-level emergency care, including, but not limited to, basic airway management, cardiopulmonary resuscitation, controlling shock and bleeding, and splinting fractures ...

001.5b: **Defibrillator** means an automatic, semiautomatic, or manual device that delivers an electric shock at a preset voltage to the myocardium through the chest wall and that is used to restore the normal cardiac rhythm and rate when the heart has stopped beating or is fibrillating.

001.5c: **Emergency medical technician** means **EMT**.

001.5d: **Emergency medical technician-intermediate (EMT-I)** ...

001.5e: **Emergency medical technician-paramedic (EMT-P)** ...

001.6: **First Responder** means an individual who is registered by the board to perform, at a minimum, basic emergency skills before the arrival of a licensed ambulance service, and is a member of an organized service ...

001.7: **License** means authority granted by the board for the operation of an ambulance service in the state of Minnesota.

001.9a: **Part-time advance life support** means rendering basic life support and advanced life support for less than 24 hours of every day.

001.9b: **Physician** means ...

001.9c: **Physician assistant** means ...

001.9d: **Pre-hospital care data** means information collected by ambulance service personnel about the circumstances related to an emergency response and patient care activities provided by the ambulance service personnel in a pre-hospital setting.

001.12: **Registered nurse** means ...

001.14: **Training program coordinator** ...

001.15: **Volunteer ambulance assistant** ...

**144E.01: Emergency Medical Services Regulatory Board ...**

**02 to 05: Staff, Member, etc.**

144E.01.6: **Duties of Board.**

(a) The Emergency Medical Services Regulatory Board shall:

(1) administer and enforce the provisions of this chapter and other duties as assigned to the board;

(2) advise applicants for state or federal emergency medical services funds, review and comment on such applications, and approve the use of such funds unless otherwise required by federal law;

(3) make recommendations to the legislature on improving the access, delivery, and effectiveness of the state's emergency medical services delivery system; and

(4) establish procedures for investigating, hearing, and resolving complaints against emergency medical services providers.

(b) The Emergency Medical Services Board may prepare an initial work plan, which may be updated biennially. The work plan may include provisions to:

(1) prepare an emergency medical services assessment which addresses issues affecting the statewide delivery system;

(2) establish a statewide public information and education system regarding emergency medical services;

(3) create, in conjunction with the Department of Public Safety, a statewide injury and trauma prevention program; and

- (4) designate an annual emergency medical services personnel recognition day.

**144E.05 General authority.**

**144.E.05-1: Receiving Grants or gifts.**

144.E.05-2: **Contracts.**

**144E.06: Primary service areas:**

The board shall adopt rules defining primary service areas under which the board shall designate each licensed ambulance service as serving a primary service area or areas.

**144E.10: Ambulance service licensing.**

**144E.101 Ambulance service requirements.**

144E.101-1: **Personnel:**

- (a) No publicly or privately owned ambulance service shall be operated in the state unless its ambulance service personnel are certified, appropriate to the type of ambulance service being provided, according to section [144E.28](#) or meet the staffing criteria specific to the type of ambulance service.

(b) An ambulance service shall have a medical director as provided under section [144E.265](#).

144E/101-2: **Patient care:** When a patient is being transported, at least one of the ambulance service personnel must be in the patient compartment. If advanced life support procedures are required, an EMT-P, a registered nurse qualified under section [144E.001](#), subdivision 3a, clause (2), item (i), or a physician assistant qualified under section [144E.001](#), subdivision 3a, clause (3), item (i), shall be in the patient compartment.

144E.101-3: **Continual service:** An ambulance service shall offer service 24 hours per day every day of the year, unless otherwise authorized under subdivisions 8 and 9.

Sub-divn. 4: **Denial of service prohibited:** An ambulance service shall not be denied pre-hospital care to a person needing emergency ambulance service because of inability to pay or because of the source of payment for services if the need develops within the licensee's primary service area or when responding to a mutual aid call. Transport for the patient may be limited to the closest appropriate emergency medical facility.

Sub-divn. 5: **Types of service.** The board shall regulate the following types of ambulance service:

- (i) basic life support;

- (ii) advanced life support;
- (iii) part-time advanced life support; and
- (iv) specialized life support.

**Sub-divn. 6: Basic life support:**

- (a) Except as provided in paragraph (e), a basic life support ambulance shall be staffed by at least two ambulance service personnel, at least one of which must be an EMT, who provide a level of care so as to ensure that:
  - (1) life-threatening situations and potentially serious injuries are recognized;
  - (2) patients are protected from additional hazards;
  - (3) basic treatment to reduce the seriousness of emergency situations is administered; and
  - (4) patients are transported to an appropriate medical facility for treatment.
- (b) A basic life support service shall provide basic airway management.

- (c) By January 1, 2001, a basic life support service shall provide automatic defibrillation, as provided in section [144E.103](#), subdivision 1, paragraph (b).
  
- (d) A basic life support service licensee's medical director may authorize the ambulance service personnel to carry and to use medical antishock trousers and to perform intravenous infusion if the ambulance service personnel have been properly trained.
  
- (e) Variation of facilities by Driver of an ambulance of service: ...

**Sub-divn. 7: Advanced life support:**

- (a) An advanced life support ambulance shall be staffed by at least:
  - (1) one EMT and one EMT-P;
  
  - (2) one EMT and one registered nurse who is an EMT, is currently practicing nursing, and has passed a paramedic practical skills test approved by the Board and administered by a training program; or
  
  - (3) one EMT and one physician assistant who is an EMT, is currently practicing as a physician assistant, and has passed a paramedic practical skills test approved by the board and administered by a training program.

- (b) An advanced life support service shall provide basic life support, as specified under subdivision 6, paragraph (a), advanced airway management, manual defibrillation, and administration of intravenous fluids and pharmaceuticals.
  
- (c) In addition to providing advanced life support, an advanced life support service may staff additional ambulances to provide basic life support according to subdivision 6. When routinely staffed and equipped as a basic life support service according to sub-division 6 and section [144E.103](#), sub-division 1, the vehicle shall not be marked as advanced life support.
  
- (d) An ambulance service providing advanced life support shall have a written agreement with its medical director to ensure medical control for patient care 24 hours a day, seven days a week. The terms of the agreement shall include a written policy on the administration of medical control for the service. The policy shall address the following issues:
  - (i) two-way communication for physician direction of ambulance service personnel;
  
  - (ii) patient triage, treatment, and transport;
    - (i) use of standing orders; and

- (ii) the means by which medical control will be provided 24 hours a day.

The agreement shall be signed by the licensee's medical director and the licensee or the licensee's designee and maintained in the files of the licensee.

- (e) When an ambulance service provides advanced life support, the authority of an EMT-P, Minnesota registered nurse-EMT, or Minnesota registered physician assistant-EMT to determine the delivery of patient care prevails over the authority of an EMT.

**Sub-divn. 8: Part-time advanced life support:**

- (a) A part-time advanced life support service shall meet the staffing requirements under subdivision 7, paragraph (a); provide service as required under subdivision 7, paragraph (b), for less than 24 hours every day; and meet the equipment requirements specified in section [144E.103](#).
- (b) A part-time advanced life support service shall have a written agreement with its medical director to ensure medical control for patient care during the time the service offers advanced life support. The terms of the agreement shall include a written policy on the administration of medical control for the service and address the issues specified in sub-division 7, para (d).

Sub-divn. 9: **Specialized life support:** A specialized ground life support service providing advanced life support shall be staffed by at least one EMT and one EMT-P, registered nurse, or physician assistant. A specialized life support service shall provide basic or advanced life support as designated by the board, and shall be restricted by the board to:

- (1) operation less than 24 hours of every day;
- (2) designated segments of the population;
- (3) certain types of medical conditions; or
- (4) air ambulance service that includes fixed-wing or rotor-wing.

Sub-divn. 10: **Driver:** A driver of an ambulance must possess a current driver's license issued by any state and must have attended an emergency vehicle driving course approved by the licensee. The emergency vehicle driving course must include actual driving experience.

Sub-divn. 11: **Personnel roster and files:**

- (a) An ambulance service shall maintain:
  - (1) at least two ambulance service personnel on a written on-call schedule;

- (2) a current roster of its ambulance service personnel, including the name, address, and qualifications of its ambulance service personnel; and
  - (3) files documenting personnel qualifications.
- (b) A licensee shall maintain in its files the name and address of its medical director and a written statement signed by the medical director indicating acceptance of the responsibilities specified in section [144E.265](#), subdivision 2.

Sub-divn. 12: **Mutual aid agreement:** A licensee shall have a written agreement with at least one neighboring licensed ambulance service for coverage during times when the licensee's ambulances are not available for service in its primary service area. The agreement must specify the duties and responsibilities of the agreeing parties. A copy of each mutual aid agreement shall be maintained in the files of the licensee.

Sub-divn. 13: **Service outside primary service area:** A licensee may provide its services outside of its primary service area only if requested by a transferring physician or ambulance service licensed to provide service in the primary service area when it can reasonably be expected that:

- (1) the response is required by the immediate medical need of an individual; and
- (2) the ambulance service licensed to provide service in the primary service area is unavailable for appropriate response.

**144E.103 Equipment:**

**Sub-divn 1. General requirements.**

- (a) Every ambulance in service for patient care shall carry, at a minimum:
  - (1) oxygen;
  - (2) airway maintenance equipment in various sizes to accommodate all age groups;
  - (3) splinting equipment in various sizes to accommodate all age groups;
  - (4) dressings, bandages, and bandaging equipment;
  - (5) an emergency obstetric kit;

(6) equipment to determine vital signs in various sizes to accommodate all age groups;

(7) a stretcher;

(8) a defibrillator; and

(9) a fire extinguisher.

(b) A basic life support service has until January 1, 2001, to equip each ambulance in service for patient care with a defibrillator.

Sub-divn. 2: **Advanced life support requirements:** In addition to the requirements in subdivision 1, an ambulance used in providing advanced life support must carry drugs and drug administration equipment and supplies as approved by the licensee's medical director.

Sub-divn. 3: **Storage:** All equipment carried in an ambulance must be securely stored.

Sub-divn. 4: **Safety restraints:** An ambulance must be equipped with safety straps for the stretcher and seat belts in the patient compartment for the patient and ambulance personnel.

**144E.11: Ambulance service application procedure: ...**

**144E.121 Air ambulance service requirements.**

Sub-division 1: **Aviation compliance**

Sub-division 2: **Personnel**

Sub-division 3: **Equipment**

**144E.123: Pre-hospital care data:**

Sub-division 1: **Collection and maintenance**

Sub-division 2: **Copy to receiving hospital**

Sub-division 3: **Review**

Sub-division 4: **Penalty:** Failure to report all information required by the board under this section shall constitute grounds for license revocation.

**144E.125: Operational procedures:**

A licensee shall establish and implement written procedures for responding to ambulance service complaints, maintaining ambulances and equipment, procuring and storing drugs, and controlling infection. The licensee shall maintain the procedures in its files.

**144E.127: Inter-hospital transfer:**

When transporting a patient from one licensed hospital to another, a licensee may substitute for one of the required ambulance service personnel, a physician, a registered nurse, or physician's assistant who has been trained to use the equipment in the ambulance and is knowledgeable of the licensee's ambulance service protocols.

**144E.13: Temporary license**

**144E.14: Transfer of license or ownership**

**144E.15: Relocation of base of operations**

**144E.16 Rules; local standards:**

Sub-division 1: Repealed, 1999 c 245 art 9 s 66.

Sub-division 2: Repealed, 1999 c 245 art 9 s 66.

Sub-division 3: Repealed, 1999 c 245 art 9 s 66.

Sub-division 4: **Rules:** The board may adopt rules needed to regulate ambulance services in the following areas:

- (1) applications for licensure;
- (2) personnel qualifications and staffing standards;
- (3) quality of life support treatment;

- (4) restricted treatments and procedures;
- (5) equipment standards;
- (6) ambulance standards;
- (7) communication standards, equipment performance and  
maintenance, and radio frequency assignments;
- (8) advertising;
- (9) scheduled ambulance services;
- (10) ambulance services in time of disaster;
- (11) basic, intermediate, advanced, and refresher emergency care course  
programs;
- (12) continuing education requirements;
- (13) trip reports;
- (14) license fees, vehicle fees, and expiration dates; and

(15) waivers and variances.

**Sub-division 5: Local government's powers:**

- (a) Local units of government may, with the approval of the board, establish standards for ambulance services which impose additional requirements upon such services. Local units of government intending to impose additional requirements shall consider whether any benefit accruing to the public health would outweigh the costs associated with the additional requirements.

The regulations presented by the local unit of government shall not conflict with rules made by the Board.

**144E.18: Inspections:**

The board may inspect ambulance services as frequently as deemed necessary to determine whether an ambulance service is in compliance with sections [144E.001](#) to [144E.33](#) and rules adopted under those sections. The board may review at any time documentation required to be on file with a licensee.

**144E.19: Disciplinary action:**

Sub-division 1: **Suspension; revocation; nonrenewal:**

The board may suspend, revoke, refuse to renew, or place conditions on the license of a licensee upon finding that the licensee has violated a provision of this chapter or rules adopted under this chapter or has ceased to provide the service for which the licensee is licensed.

Sub-division 2: **Notice; contested case.**

Sub-division 3: **Temporary suspension.**

**144E.265: Medical director:**

Sub-division 1: **Requirements.**

Sub-division 2: **Responsibilities:**

Responsibilities of the medical director shall include, but are not limited to:

- (1) approving standards for training and orientation of personnel that impact patient care;
- (2) approving standards for purchasing equipment and supplies that impact patient care;
- (3) establishing standing orders for prehospital care;
- (4) approving written triage, treatment, and transportation guidelines for adult and pediatric patients;

- (5) participating in the development and operation of continuous quality improvement programs including, but not limited to, case review and resolution of patient complaints;
- (6) establishing procedures for the administration of drugs; and
- (7) maintaining the quality of care according to the standards and procedures established under clauses (1) to (6).

Sub-division 3: **Annual assessment; ambulance service.**

By medical director.

**144E.27: First responder registration.**

Subdivision 1. **Training programs, Registration, Renewal, Denial, suspension, revocation, Temporary suspension.**

**144E.275: Medical response unit registration: Registration, qualifications, Expiration, Renewal.**

**144E.28: Certification of EMT, EMT-I, and EMT-P.**

**Requirements, Expiration Dates, Reciprocity, Forms of disciplinary action, Denial, suspension, revocation, Temporary suspension, Renewal, Reinstatement.**

**144E.283: EMT instructor qualifications.**

**144E.285: Training programs.**

**Approval required.**

**EMT-P requirements, Expiration, Disciplinary action, Temporary suspension, Audit.**

**144E.286: Examiner qualifications for emergency medical technician testing.**

**144E.287: Diversion program.**

**144E.29: Fees.**

(a) The board shall charge the following fees:

- (1) initial application for and renewal of an ambulance service license, \$150;

- (2) each ambulance operated by a licensee, \$96. The licensee shall pay an additional \$96 fee for the full licensing period or \$4 per month for any fraction of the period for each ambulance added to the ambulance service during the licensing period;
  - (3) initial application for and renewal of approval for a training program, \$100; and
  - (4) duplicate of an original license, certification, or approval, \$25.
- (b) With the exception of paragraph (a), clause (4), all fees are for a two-year period. All fees are non-refundable.
- (c) Fees collected by the board shall be deposited as non-dedicated receipts in the general fund.

**144E.30: Cooperation; Board powers:**

Sub-division 3: **Cooperation during investigation.**

Sub-division 4: **Injunctive relief.**

Sub-division 5: **Subpoena power.**

**144E.305: Reporting misconduct:**

Sub-division 1: **Voluntary reporting.**

Sub-divn. 2: **Mandatory reporting.**

Sub-divn. 3: **Immunity:** Immunity for good faith reporting from civil actions on reporting Individual, Licensee, health care facility, business or organization.

**144E.31: Correction order and fines by Board.**

**144E.35: Reimbursement to nonprofit ambulance services.**

Sub-division 1: **Repayment for volunteer training.**

Sub-division 2: **Procedure.**

**144E.37: Comprehensive advanced life support.**

Comprehensive advanced life support educational program to train rural medical personnel, including physicians, physician assistants, nurses for emergencies – by Board.

**144E.50 Emergency medical services fund.**

Sub-division 1: name of fund.

**Sub-division 2: Establishment and purpose.**

In order to develop, maintain, and improve regional emergency medical services systems, the Emergency Medical Services Regulatory Board shall establish an emergency medical services system fund.

The fund shall be used for the general purposes of –

- (1) promoting systematic, cost-effective delivery of emergency medical care throughout the state;
- (2) identifying common local, regional, and state emergency medical system needs and providing assistance in addressing those needs;
- (3) providing discretionary grants for emergency medical service projects with potential regionwide significance;
- (4) providing for public education about emergency medical care;
- (5) promoting the exchange of emergency medical care information;
- (6) ensuring the ongoing coordination of regional emergency medical services systems; and

- (7) establishing and maintaining training standards to ensure consistent quality of emergency medical services throughout the state.

**Sub-divn. 3: Definition – Board.**

Sub-divn. 4: **Use and restrictions.** Designated regional medical services system funds to support local and regional emergency medical services as determined within the region, with particular emphasis given to supporting and improving emergency trauma and cardiac care and training. No part of a region's share of the fund may be used to directly subsidize any ambulance service operations or rescue service operations or to purchase any vehicles or parts of vehicles for an ambulance service or a rescue service.

Sub-divn. 5: **Distribution:** Money from the fund shall be distributed according to this sub-division.

- (1) Ninety-five percent of the fund shall be distributed annually on a contract for services basis with each of the eight regional emergency medical services systems designated by the board.

- (2) The systems shall be governed by a body consisting of appointed representatives from each of the counties in that region and shall also include representatives from emergency medical services organizations.

- (3) The board shall contract with a regional entity only if the contract proposal satisfactorily addresses proposed emergency medical services activities in the following areas: (i) personnel training; (ii) transportation coordination; (iii) public safety agency cooperation; (iv) communications systems maintenance and development; (v) public involvement; (vi) health care facilities involvement; and (vii) system management.
- (4) If each of the regional emergency medical services systems submits a satisfactory contract proposal, then this part of the fund shall be distributed evenly among the regions.
- (5) If one or more of the regions does not contract for the full amount of its even share or if its proposal is unsatisfactory, then the board may reallocate the unused funds to the remaining regions on a pro rata basis.
- (6) 5% of the fund shall be used by the board to support region-wide reporting systems and to provide other regional administration and technical assistance.

Sub-divn. 6: **Audit of regional emergency medical services board.**

**144E.52: Funding for the emergency medical services regions.**

The Emergency Medical Services Regulatory Board shall distribute funds appropriated from the general fund equally among the emergency medical service regions. Each regional board may use this money to reimburse eligible emergency medical services personnel for continuing education costs related to emergency care that are personally incurred and are not reimbursed from other sources. Eligible emergency medical services personnel include, but are not limited to, dispatchers, emergency room physicians, emergency room nurses, first responders, emergency medical technicians, and paramedics.

There are some of the important statutes/Rules in force elsewhere which can form the basis for a similar system in India so as to fulfil the needs of our society, referred to by the Supreme Court of India in Parmanand Katara and other cases.

In the next chapter, (Chapter-IV), we propose to give our recommendations for a law to be made in India, so far as requiring hospitals and medical practitioners to compulsorily provide emergency medical care without rising objections.

So far as ambulances are concerned, except to the extent transfer from one hospital to another, we are not giving any recommendation though there are separate statutes giving ambulances, in USA, as stated above.

## CHAPTER V

### RECOMMENDATIONS FOR MANDATORY EMERGENCY MEDICAL CARE BY HOSPITALS AND MEDICAL PRACTITIONERS

In the light of the discussion in Chapters I and II, and the principles applied for mandatory emergency medical care in hospitals in USA in particular, as described in chapter III, we propose to give our recommendations, keeping in view the observations of the Supreme Court in Parmanand Katara v. Union of India AIR 1989 SC 2039, Paschim Banga Khet Mazdoor Samiti v. State of West Bengal: 1996(4) SCC 37 and Indian Medical Association v. V.S. Shanta 1995(6) SCC 651 and decision of the National Consumer Redressal Commission in Pravat Kumar Mukherjee v. Ruby General Hospital (25.4.2005).

We are drafting a Model Law for the States in view of the observation of the Supreme Court. It may be noted that ‘hospitals’ fall under Entry 6 of State List in Schedule VII of the Constitution of India. The reference to medical practitioners in this Bill is purely incidental.

Duty of Hospitals and Medical Practitioners:

We have noticed the observations of the Supreme Court in Parmanad Katara v. Union of India : AIR 1989 SC 2039 that hospitals and medical practitioners have a duty to provide emergency medical care.

In that case, the Court observed that “the effort to save the persons should be the top priority not only of the medical professionals but even of the police or any other citizen who happens to be connected with the matter or who happens to notice such an accident or a situation”. The Court said, “it is the obligation of those who are in charge of the health of the community to preserve life so that the innocent may be protected and the guilty may be punished”. The Court further observed:

“A doctor at the Government hospital positioned to meet the State obligation is, therefore, duty bound to extend medical assistance for preserving life. Every doctor whether at a Government hospital or otherwise, has the professional obligation to extend his services with due expertise for protecting life. No law or State action can intervene to avoid/ delay the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way.”

The Court also observed:

“But on behalf of the medical profession there is one more apprehension which sometimes prevents a medical professional in spite of his desire to help the person, as he apprehends that he will be a witness and may have to face police interrogation which sometimes may need going to the police station repeatedly and waiting and also to be a witness in a Court of law where also he apprehends that he may have to go on number of days and may have to wait for a long time and may have to face sometimes long unnecessary cross-examination which sometimes may even be humiliating for a man in the medical profession and in our opinion, it is this apprehension which prevents a medical professional who is not entrusted with the duty of handling medico-legal cases to do the needful, he always tries to avoid and even if approached, directs the person concerned to go to a State hospital and particularly to the person who is in-charge of the medico-legal cases.”

The Court directed:

“We are of the view that every doctor wherever he be within the territory of India should forthwith be aware of this position and, therefore, we direct that this decision of ours shall be published in all journals reporting decisions of this Court and adequate publicity should be given by the national media as also through the Doordarshan and All India Radio.”

Similar views were expressed in the other cases referred to above.

We are, therefore, of the opinion that it is necessary to impose a statutory duty on hospitals and medical practitioners to attend on a person who has met with an accident or who is in an emergency condition who comes before them or who is brought before them, without raising any objection and without any excuse that it is a medico-legal case and that the person must be taken to a Government hospital.

Apart from this kind of objections, there are other circumstances which are recognised today as being responsible for refusal to treat persons mentioned above. One such objection is that the person is not immediately in a position to meet the expenditure that may be involved in emergency medical treatment. Sometimes, hospitals or doctors want immediate payment. Some others are not prepared to take up cases where the person does not have insurance or has no facility for medical reimbursement either from his employer or under any other medical reimbursement scheme. These and other objections necessitate that a specific statutory provision must be made imposing a mandatory duty on hospitals and doctors to treat persons who are injured in accidents or who are in other medical emergencies. They have to first treat the patient, screen him, stabilize him and render such emergency medical care as is required or is available in the hospital or the clinic of the medical practitioner. We are also proposing a statutory scheme for reimbursement by the State Governments.

The first few hours are known as 'golden hours' for such patients for if there is no emergency medical care coming soon after the accident or other emergency medical condition, the life of the person may be lost for ever or he may remain crippled and ill beyond repair for all time.

In the United States of America, as stated in chapter III, lack of interest on the part of hospitals to attend on victims of accidents, those in an emergency medical condition and women under labour led to the passing of a law called EMTALA STATUTE (42 USC 1395 DD) (Emergency Medical Treatment and Labour Act) by amending the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). That Act made it a mandatory duty on the part of hospitals to attend on such persons. The Act contains an entire scheme of screening, stabilizing and rendering emergency treatment. It also deals with situations where the hospital is not sufficiently equipped to provide stabilization or emergency treatment and in that event, the hospital has to transfer the person to another hospital. In certain cases, it cannot transfer unless the patient is stabilized. A number of safeguards are provided in Emtala as to what should be done for transfer of a person to another hospital. The Emtala also creates offences against those who violate the duties envisaged by it.

In this Report and the Bill, we have adopted some of the principles stated in Emtala and we have made suitable changes for our purposes in India.

(A) We recommend statutory duties on hospitals and medical practitioners

We, therefore, recommend a section in the proposed law to make it mandatory to direct medical assistance in accidents and emergencies precluding the hospitals or doctors from raising any objection on the following grounds:-

- (a) that it is a medico-legal case requiring information to be given to the police authorities, or
  
- (a) that the person is not immediately in a position to make payment for screening and emergency medical treatment or that immediate payment should be made as a condition precedent for treatment, or
  
- (b) that the person does not have medical insurance or is not a member of any medical scheme providing for medical reimbursement.

In addition, we propose that “no other unreasonable objection” can be raised for giving emergency medical treatment.

The draft of the proposed section 3 is as follows:

**“Duty of duty doctors in hospitals and private medical practitioners**

3. It shall be the duty of every hospital and every medical practitioner to immediately attend on every person involved in an accident or who is purportedly in an emergency condition, when such a person has come or has been brought to the hospital or to the private medical practitioner and screen or transfer such person as stated in section 4 and when the screening reveals the existence of an emergency medical condition, to stabilize or transfer such person as

stated in section 5 and afford them, such medical treatment as may be urgently called for -

- (i) without raising any objection that it is a medico-legal case requiring information to the police authorities,
  - (ii) whether or not such a person is immediately in a position to make payment for screening and emergency medical treatment, and without insisting on payment as a condition precedent.
  - (iii) whether or not such a person has medical insurance or is a member of any medical scheme of the person's employer or to a scheme which otherwise provides for medical reimbursement, and
  - (iv) without raising any other unreasonable objection.”
- (B) ‘Screening’ a person to determine if he is in an ‘emergency medical condition.

#### Definition of ‘emergency medical condition’

The next requirement is to make it mandatory for “screening” the person to find out whether the person requires emergency medical treatment in the hospitals, i.e. treatment as an in-patient or whether he could be treated in the out patient department of the hospital. Even a private medical practitioner can conduct such a screening. The results of the screening must be documented by the hospital or doctor in their registers. Section 4 of the Bill provides for mandatory screening as follows:

### **“Screening of the person**

4. Whenever such a person referred to in section 3, is brought or comes to the hospital or medical practitioner, it shall be their duty to provide an appropriate medical screening examination within the capability of the hospital or the medical practitioner, as the case may be, for the purpose of determining whether or not an emergency medical condition exists.”

Provided that if such hospital or medical practitioner, as the case may be, is not having capability for conducting appropriate medical screening examination, it shall be their duty to arrange for the transfer of the person to a hospital or to another medical practitioner which or who, in their opinion, has the necessary capabilities for such medical screening examination.”

Once the mandatory screening is done, it may reveal that the person is or is not in an emergency medical condition.

By emergency medical condition, (which we propose to define) we mean a medical condition manifesting acute symptoms of sufficient severity (including severe pain) where the absence of emergency medical treatment could reasonably be expected to result in

- (i) death of the person,
- (ii) serious jeopardy in the health of the person (or in the case of a pregnant woman, in her health and the health of the unborn child), or
- (iii) serious impairment of bodily functions,
- (iv) serious dysfunction of any bodily organ or part,

We propose to add an Explanation as to what is emergency medical condition of a pregnant woman such as where there is no adequate time to effect a safe transfer of the person to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or her unborn child.”

(C) Emergency Medical Treatment to a person who is in emergency medical condition.

Stabilising a person:

If a person is in an emergency medical condition, as revealed by the screening, he must be given emergency medical treatment including stabilization and further treatment.

We propose to define ‘emergency medical treatment’ as follows:

“‘Emergency medical treatment’ means the action that is required to be taken, after screening of a person injured in an accident or who is in an emergency medical condition, as to the stabilization of the person and the rendering of such further treatment as may, in the opinion of the hospital or medical practitioner be necessary for the purpose of preventing aggravation of the medical condition of the person or his death and in the case of a pregnant woman, for the purpose of safe delivery and safeguarding the life of the woman and the child.”

“Stabilization with respect to an emergency condition means –

- (i) to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or
  - (ii) to provide, with respect to a pregnant woman who is having contractions, for the safe delivery of the child (including the placenta),
- and the word ‘stabilized’ shall be understood accordingly.”

Duty of hospital and medical practitioner to stabilize the medical condition is provided in section 5(i) of the Bill as follows:

**“Stabilizing the person and transfer**

5. Wherever in respect of a person referred to in section 3, screening, as stated in section (4) has been done and it has been determined that an emergency medical condition exists which requires to be urgently treated, it shall be the duty of the hospital or medical practitioner, as the case may be, subject to the provisions of section 6, either -

- (i) to provide, within the staff and facilities available at the hospital or with the medical practitioner, such further medical examination and such medical treatment as may be required to stabilize his medical condition, or
- (ii) .. .. .”

(D) After stabilization, transfer, where necessary

But, where the necessary facilities for stabilization are not available with a hospital or medical practitioner, it is necessary to arrange for transfer to another hospital or medical practitioner, who or which, in the opinion of the transferring hospital or medical practitioner, can stabilize the person and provide further medical treatment.

This is provided in section 5(ii) of the Bill as follows:

**“Stabilizing the person and transfer**

5. Wherever in respect of a person referred to in section 3, screening, as stated in section (4) has been done and it has been determined that an emergency medical condition exists which requires to be urgently treated, it shall be the duty of the hospital or medical practitioner, as the case may be, subject to the provisions of section 6, either -

- (i) .. .. .
- (ii) where such facilities are not available with the hospital or the medical practitioner, or the person request for a transfer arrange for the transfer of the person to a hospital or to another medical practitioner which or who in their opinion has the necessary facilities for such further medical examination, stabilization and further medical treatment and then the provisions of section 8 shall apply.”

(E) Refusal for transfer for treatment or transfer

If a person injured in an accident or in serious medical condition refuses to give consent either for emergency medical treatment (i.e.

including stabilization) or for treatment after stabilization, the hospital or medical practitioner must get his written informed consent. Similarly, where for lack of facilities in the hospital or with the medical practitioner, or where the patient requests for transfer, he has to be transferred to another hospital or medical practitioner, and the person refuses for transfer, the person's written informed refusal must be obtained and if such person refuse to give consent, the duty of the hospital or medical practitioner, as provided in Section 5, shall cease to exist. This is provided in proviso to section 5. Proviso reads as follows:

“Provided that where such person refuses to give consent for treatment or transfer, as stated in section 6, thereafter, duty of the hospital or medical practitioner shall cease to exist.”

This is provided in section 6 of the Draft Bill.

**“Refusal by the person to consent for treatment or transfer**

6. Where in respect of a person referred to in section 3, it has been determined that he requires emergency medical treatment or has to be transferred as stated in section 5, and where such person is mentally or physically in a position to refuse in writing,

- (i) refuses to consent to emergency medical treatment after the hospital or the medical practitioner, as the case may be, has offered to provide further emergency medical treatment, and after being informed of the risks and benefits of such emergency medical treatment, the duty doctor in the hospital or the medical practitioner shall take all reasonable steps to obtain the person's

written informed consent in respect of his refusal to consent for emergency medical treatment; or

- (ii)refuses to consent for transfer to another medical facility after the hospital or the medical practitioner, as the case may be, has offered to transfer him to another medical facility in accordance with section 8, and after being informed of the risks and benefits to such person of such transfer, the duty officer in hospital or the medical practitioner, shall take all reasonable steps to obtain the person’s written informed consent in respect of his refusal to consent to such transfer.”

(F) No transfer before stabilization:

As proposed in section 7 of the Bill, where a person requests for a transfer, referred to in section 5(ii), but is in an emergency medical condition which has not stabilized, he should not be transferred if facilities for stabilization are available without following the procedure; unless

- (a) the person, upon being informed of the obligations of the duty doctor or of the medical practitioner as stated in section 3 and of the risk of transfer, requests for transfer in writing without stabilization, to another medical facility, or
- (b) the duty doctor in the hospital or the medical practitioner, as the case may be, has signed a certificate that, based upon information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate emergency medical treatment at another hospital or with another medical practitioner outweigh the increased risks to the person and in the case of a

pregnant woman under labour, to the unborn child, of the effects of transfer,  
and unless the transfer is an ‘appropriate transfer’.

(G) Transfer must be an appropriate transfer: Care during transfer, ambulance & records etc.:

For transfer, the hospital or medical practitioner must call for an ambulance and it shall be the duty of agencies running ambulances to provide the ambulance without raising any objection that it should be paid first. If no ambulance is available, the hospital or medical practitioner has to seek the help of the police to requisition any vehicle for transport. The transferring hospital or doctor must provide for medical facilities during the transport. Section 8 which deals with these aspects under the heading ‘appropriate transfer’ reads as follows:

**“Appropriate transfer**

8. A transfer to another hospital or medical practitioner shall be treated as an appropriate transfer if

(a) the transferring hospital or the medical practitioner provides medical treatment within its or his capacity which minimizes the risks to the health of the person and in the case of a pregnant woman in labour, the health of the unborn child during such transfer, and

- (b) the receiving hospital or the medical practitioner has available space, qualified personnel and infrastructure for providing emergency medical treatment to the person and thereafter, in so far as the stabilization and further medical treatment are concerned, the duties cast under section 3 shall apply to the receiving hospital or the receiving medical practitioner.
- (c) the transferring hospital or medical practitioner sends to the receiving hospital or receiving medical practitioner
  - (i) all medical records (or copies thereof), relating to the screening and the emergency medical condition of the person, which are available at the time of such transfer, including records relating to the person's medical condition, observation of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent, if any, and
  - (ii) a certificate of the hospital or medical practitioner that, based upon the information available at the time of transfer that the medical benefits reasonably expected from the provision of appropriate medical treatment at the receiving hospital outweigh the increased risks, on account of the transfer, to the person and, in case of a women under labor, to the unborn child.
- (d) the transferring hospital or medical practitioner provides necessary medical facilities including life support systems and qualified personnel within the capacity of the transferring hospital or medical practitioner, to accompany the person during the

period covered by transport to the receiving hospital or receiving medical practitioner.

- (e) the transferring hospital or medical practitioner has informed, by telephone or otherwise, the hospital or medical practitioner to which or to whom the person is being transferred that a person in an emergent medical is being transferred and furnish the details of the person's condition,

Provided that where any ambulance or other transport vehicle is not available with the transferring hospital or medical practitioner, it or he shall call for the services of an ambulance or other transport vehicle and in case of non-availability thereof, shall seek the assistance of any police authorities having jurisdiction over the area where the transferring hospital or the clinic of the medical officer is located, for requisitioning a transport vehicle,

Provided further that when any ambulance or vehicle is called for, by such hospital or medical practitioner or by police authorities as aforesaid, the agency running the ambulance or the owner or person operating the vehicle shall not raise any objection to provide the ambulance or other vehicle on any of the grounds referred to in clauses (i) to (iv) in section 3.”

(H) Maintenance of Records by hospitals and medical practitioners:

It is necessary that the hospital or medical practitioner maintain records. The details are set out in section 9 of the Draft Bill.

“Every hospital, medical practitioner, -- shall maintain a separate register containing the following information:

- (a) name and address of the person injured, date or place of accident as reported, nature of injuries and other relevant details and the person who brought him,
- (b) name and address of the person purportedly in emergency medical condition, nature of emergency and nature of medical condition and the person who brought him,
- (c) details of the screening tests done and the determination of emergency condition,
- (d) whether the person is in a position to give informed consent for emergency medical treatment including stabilization or for transfer or if he refused them,
- (e) whether emergency medical treatment was not given for want of facilities, if so, which facilities,
- (f) nature of tests done, results thereof, surgery conducted, who attended, time, date and hours of treatment,
- (g) details of transfer to another hospital or medical practitioner
- (h) details of fee paid to consultants or laboratories,
- (i) details of expenditure incurred,
- (j) other particulars to show that the hospital or doctor complied with its or his duties under the Act.
- (k) Such other particulars as may be prescribed.”

- (I) Scheme for reimbursement to hospitals and medical practitioners, ambulance for transfer etc. to be framed by State Governments: States to allocate Funds:

The State Government must frame a scheme for reimbursement to hospitals, medical practitioners, ambulances and those who provide vehicles for transport. The State must notify an authority which will deal with reimbursement. The State must set apart substantial money for purpose of reimbursement. The scheme must provide for the procedure for reimbursement. The scheme must be published in State Gazette. These are provided in the Draft Bill in section 10, which reads as follows:

**“Scheme of State Government for reimbursement of expenses**

10(1) The State Government shall frame a scheme, within one month from the date of commencement of this Act, for the purpose of reimbursement of the expenses incurred in the course of performance of the duties referred to in sections 3 to 9, by a hospital or medical practitioner or an agency which has provided ambulance facilities or other person who has provided a vehicle for transfer as mentioned in clause (e) of section 8.

- (2) Such a scheme shall, inter-alia, refer to –
- (a) the authority which will be in-charge of reimbursement of expenses,
  - (b) the conditions which have to be satisfied before reimbursement of expenses can be granted,
  - (c) the manner in which applications may be made for reimbursement and what supporting documents have to be submitted or to whom the reimbursement can be made,

- (d) the manner in which the material produced by the person seeking reimbursement has to be scrutinized or verified,
- (e) the procedure for giving a hearing to the applicant in respect of the reimbursement claimed,
- (f) the time frame for reimbursement,
- (g) the mode of repayment, and
- (h) other details which may result in an effective scheme of reimbursement of expenses incurred.

(1) The State Government shall allocate necessary funds for the purpose of reimbursement of the expenses incurred by those referred to in sub-section (1),

(2) The scheme framed under sub-section (1) and subsequent changes, if any, made thereto from time to time, shall be published in the Gazette of the State Government.

(J) Penalties for breach of duties by hospitals, medical practitioners, ambulances for transfer etc.:

There must be penalties against hospitals, medical practitioners or those who run ambulances or those whose vehicles are requisitioned by police for transport.

There must be provision for imprisonment or fine for those who fail in their duties – including those in-charge of management or responsible for giving emergency medical aid in a hospital.

There must be provision for cancellation of licenses to hospitals.

There must also be provision for disciplinary action against medical practitioners.

This shall be in addition to penalties prescribed under any other law in force.

These are all provided in section 11.

**“Penalties**

11. (1) Any person managing or responsible for the management of the hospital or a medical practitioner or agency running an ambulance or owner or operator of a vehicle which or who refuses to perform all or any of the duties referred to in sections 3 to 9, without justifiable reason, shall be liable for punishment by way of imprisonment for a period which may extend upto six months or for fine which may extend upto rupees ten thousand or for both.

(2) Any hospital refusing to perform the duties referred to in sections 3 to 9 without justifiable reason, may be proceeded against for suspension or cancellation of any of its licenses under which it is running the hospital, in addition to the penalty referred to in sub-section (1) that may be imposed on the persons owning or managing the hospital.

(1) Any medical practitioner attached to a hospital or any other medical practitioner who refuses to perform the duties referred to in sections 3 to 9, without justifiable reason may, in addition to the penalty provided in sub-section (1), be subjected to such disciplinary action as may be determined by the State Medical Council.

- (2) These provisions will be in addition to the penalties prescribed under any other law in force.”

(L) Rules to be framed by State Government:

We have provided that the State Government may make rules for implementation of the provisions of the Act and that the rules will be published in the State Gazette. This is provided in section 12.

**“Rule making powers**

12. (1) The State Governments may make rules for the purpose of enforcement of the provisions of this Act and publish the same in the State Gazette.
- (2) The rules referred to in sub-section (1) shall be laid before the legislature within a period of one month from the date of publication of the rules in the State Gazette as stated in sub-section (1).”

The Draft of the Bill is annexed with this Report. We recommend accordingly.

**( Justice M. Jagannadha Rao )**  
**Chairman**

**( R.L. Meena )**  
**Vice Chairman**

**Dated: 31.08.2006**

**( Dr. D.P. Sharma )**  
**Member-Secretary**

**ANNEXURE**

MODEL LAW  
ON  
MEDICAL TREATMENT AFTER ACCIDENTS AND  
DURING EMERGENCY MEDICAL CONDITION AND WOMEN IN  
LABOUR, BILL

A Bill to mandate emergency medical treatment by hospitals and medical practitioners to victims of accidents and those in other emergency medical condition including women in labour without raising any objection or objections that the cases are medico-legal cases or any other objection and without demanding any payment as a condition precedent for such treatment and to provide for scheme for reimbursement of emergency medical treatment and for other matters incidental thereto:

Chapter I

Preliminary

**Short title and commencement**

1. (1) This Act may be called the Medical Treatment After Accidents and During Emergency Medical Condition Act, 2006.
- (2) It shall extend to the territories of the State of .....
- (3) It shall come into force on such date as the State Government may, by notification in the Official Gazette appoint.

## Definitions

2. In this Act, unless the context otherwise requires:

- (a) 'accident' means any accident giving rise to severe bodily pain or serious injury to human beings who are in emergency medical condition;
- (a) 'emergency medical condition' means a medical condition manifesting acute symptoms of sufficient severity (including severe pain) where the absence of emergency medical treatment could reasonably be expected to result in
  - (i) death of the person, or
  - (ii) serious jeopardy in the health of the person (or in the case of a pregnant woman, in her health and the health of the unborn child), or
  - (iii) serious impairment of bodily functions, or
  - (iv) serious dysfunction of any bodily organ or part.

Explanation: In the case of a pregnant woman who is having contractions, an 'emergency medical condition' shall be deemed to exist where

- (i) there is no adequate time to effect a safe transfer of the person to another hospital before delivery, or
- (ii) the transfer may pose a threat to the health or safety of the woman or her unborn child.

- (b) 'emergency medical treatment' means the action that is required to be taken, after screening of a person injured in an accident or who is in an emergency medical condition, as to the stabilization of the person and the rendering of such further treatment as may, in the opinion of the hospital or medical practitioner be necessary for the purpose of preventing aggravation of the medical condition of the person or his death and in the case of a pregnant woman, for the purpose of a safe delivery and safeguarding the life of the woman and the child.
- (c) 'medical practitioner' means a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 (102 of 1956) and who is enrolled in a State Medical Register as defined in clause (k) of that section and includes a private medical practitioner;
- (d) 'hospital' includes a nursing home, clinic medical center, medical institution having hospital emergency department or facilities for emergency medical treatment;
- (e) 'prescribed' means prescribed by Rules made under this Act;
- (f) 'stabilize' means, with respect to an emergency medical condition
  - (i) to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or

(ii) to provide, with respect to a pregnant woman who is having contractions, for the safe delivery of the child (including the placenta),

and the word 'stabilized' shall be understood accordingly.

(g) 'transfer' means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any designated medical practitioner employed by a hospital but does not include an individual who has been declared dead or leaves the facility without the permission of the doctor attending on him.

Explanation: 'designated medical practitioner' means any practitioner employed by the hospital for directing transfer outside a hospital's facility and includes any other medical practitioner temporarily discharging the functions of such designated medical practitioner.

### **Duty of duty doctors in hospitals and private medical practitioners**

3. It shall be the duty of every hospital and every private medical practitioner to immediately attend on every person involved in an accident or who is purportedly in an emergency condition, when such a person has come or has been brought to the hospital or to the private medical practitioner and screen or transfer such person as stated in section 4 and when the screening reveals the existence of an emergency medical condition, to stabilize or transfer such person as stated in section 5 and afford them, such medical treatment as may be urgently called for, -

- (i) without raising any objection that it is a medico-legal case requiring information to the police authorities,
- (ii) whether or not such a person is immediately in a position to make payment for the screening and emergency medical treatment, and without insisting on payment as a condition precedent.
- (iii) whether or not such a person has medical insurance or is a member of any medical scheme of the person's employer or to a scheme which otherwise provides for medical reimbursement, and
- (iv) without raising any other unreasonable objection.

### **Screening of the person**

4. Whenever such a person referred to in section 3, comes or is brought to the hospital or medical practitioner, it shall be their duty to provide an appropriate medical screening examination within the capability of the hospital or the medical practitioner, as the case may be, for the purpose of determining whether or not an emergency medical condition exists.

Provided that if such hospital or medical practitioner, as the case may be, is not having capability for conducting appropriate medical screening examination, it shall be their duty to arrange for the transfer of the person to a hospital or to another medical practitioner which or who in their opinion has the necessary capabilities for such medical screening examination.

### **Stabilizing the person and transfer**

5. Wherever in respect of a person referred to in section 3, screening, as stated in section 4 has been done and it has been determined that an emergency medical condition exists which requires to be urgently treated, it shall be the duty of the hospital or medical practitioner, as the case may be, either -

- (h) to provide, within the staff and facilities available at the hospital or with the medical practitioner, such further medical examination and such medical treatment as may be required to stabilize his medical condition, or
- (ii) where such facilities are not available with the hospital or the medical practitioner, or the person requests for a transfer, arrange for the transfer of the person to a hospital or to another medical practitioner which or who in their opinion has the necessary facilities for such further medical examination, stabilization and further medical treatment and then the provisions of section 8 shall apply.

Provided that where such person refuses to give consent for treatment or transfer, as stated in section 6, thereafter, duty of the hospital or medical practitioner shall cease to exist.

### **Refusal by the person to consent for treatment or transfer**

6. Where in respect of a person referred to in section 3, it has been determined that he requires emergency medical treatment or has to be transferred as stated in section 5, and where such person is mentally or physically in a position to refuse in writing,

- (i) refuses to consent to emergency medical treatment after the hospital or the medical practitioner, as the case may be, has offered to provide further emergency medical treatment, and after being informed of the risks and benefits of such emergency medical treatment, the duty doctor in the hospital or the medical practitioner shall take all reasonable steps to obtain the person's written informed consent in respect of his refusal to consent for emergency medical treatment; or
- (ii) refuses to consent for transfer to another medical facility after the hospital or the medical practitioner, as the case may be, has offered to transfer him to another medical facility in accordance with section 8, and after being informed of the risks and benefits to such person of such transfer, the duty doctor in hospital or the medical practitioner, shall take all reasonable steps to obtain the person's written informed consent in respect of his refusal to consent to such transfer.

### **Restricting transfer till person is stabilized**

7. Where a person referred to in section 3, requests for transfer but is in an emergency medical condition which has not stabilized, the hospital or the medical practitioner, as the case may be, shall not transfer the person if facilities for stabilization are available, unless

- (i) the person, upon being informed of the obligations of the duty doctor or of the medical practitioner as stated in section 3 and of

the risk of transfer, requests for transfer in writing without stabilization, to another medical facility, or

(ii) the duty doctor in the hospital or the medical practitioner, as the case may be, has signed a certificate that, based upon information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate emergency medical treatment hospital or with another medical practitioner outweigh the increased risks to the person and in the case of a pregnant woman under labour, to the unborn child, of the effects of transfer, and

(2) the transfer is an appropriate transfer as stated in subsection (8).

### **Appropriate transfer**

8. A transfer to another hospital or medical practitioner shall be treated as an appropriate transfer if

(a) the transferring hospital or the medical practitioner provides medical treatment within its or his capacity which minimizes the risks to the health of the person and in the case of a pregnant woman in labour, the health of the unborn child during such transfer, and

(b) the receiving hospital or the medical practitioner has available space, qualified personnel and infrastructure for providing emergency medical treatment to the person and thereafter, in so far as the stabilization and further medical treatment are concerned,

the duties cast under section 3 shall apply to the receiving hospital or the receiving medical practitioner.

- (c) the transferring hospital or medical practitioner sends to the receiving hospital or receiving medical practitioner
  - (i) all medical records (or copies thereof), relating to the screening and the emergency medical condition of the person, which are available at the time of such transfer, including records relating to the person's medical condition, observation of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent, if any, and
  - (ii) a certificate of the hospital or medical practitioner that, based upon the information available at the time of transfer that the medical benefits reasonably expected from the provision of appropriate medical treatment at the receiving hospital outweigh the increased risks, on account of the transfer, to the person and, in case of a women under labor, to the unborn child.
- (d) the transferring hospital or medical practitioner provides necessary medical facilities including life support systems and qualified personnel within the capacity of the transferring hospital or medical practitioner, to accompany the person during the period covered by transport to the receiving hospital or receiving medical practitioner.
- (e) the transferring hospital or medical practitioner has informed, by telephone or otherwise, the hospital or medical practitioner to which or to whom the person is being transferred that a person is

an emergent medical is being transferred and furnish the details of the person's condition,

Provided that where any ambulance or other transport vehicle is not available with the transferring hospital or medical practitioner, it or he shall call for the services of an ambulance or other transport vehicle and in case of non-availability thereof, shall seek the assistance of any police authorities having jurisdiction over the area where the transferring hospital or the clinic of the medical officer is located for requisitioning a transport vehicle,

Provided further that when any ambulance or vehicle is called for by such hospital or medical practitioner or by police authorities as aforesaid, the agency running the ambulance or the owner or person operating the vehicle, shall not raise any objection to provide the ambulance or other transport vehicle on any of the grounds referred to in clauses (i) to (iv) in section 3.

### **Maintenance of records**

9. Every hospital, medical practitioner, -- shall maintain a separate register containing the following information:
  - (a) name and address of the person injured, date or place of accident as reported, nature of injuries and other relevant details, and the person who brought him,
  - (b) name and address of the person purportedly in emergency medical condition, nature of emergency and nature of medical condition, and the person who brought him,

- (c) details of the screening tests done and the determination of emergency condition,
- (d) whether the person is in a position to give informed consent for emergency medical treatment including stabilization or for transfer or if he refused them,
- (e) whether emergency medical treatment was not given for want of facilities, if so, which facilities,
- (f) nature of tests done, results thereof, surgery conducted, who attended, time, date and hours of treatment,
- (g) details of transfer to another hospital or medical practitioner
- (h) details of fee paid to consultants or laboratories,
- (i) details of expenditure incurred,
- (j) other particulars to show that the hospital or doctor complied with its or his duties under the Act.
- (k) Such other particulars as may be prescribed.

### **Scheme of State Government for reimbursement of expenses**

10. (1) The State Government shall frame a scheme, within one month from the date of commencement of this Act, for the purpose of reimbursement of the expenses incurred in the course of performance of the duties referred to in sections 3 to 9, by a hospital or medical practitioner or an agency which has provided ambulance facilities or other person who has provided a vehicle for transfer as mentioned in clause (e) of section 8.

- (2) Such a scheme shall, inter-alia, refer to –
  - (a) the authority which will be in-charge of reimbursement of expenses,
  - (b) the conditions which have to be satisfied before reimbursement of expenses can be granted,
  - (c) the manner in which applications may be made for reimbursement and what supporting documents have to be submitted or to whom the reimbursement can be made,
  - (d) the manner in which the material produced by the person seeking reimbursement has to be scrutinized or verified,
  - (e) the procedure for giving a hearing to the applicant in respect of the reimbursement claimed,
  - (f) the time frame for reimbursement,
  - (g) the mode of repayment, and
  - (h) other details which may result in an effective scheme of reimbursement of expenses incurred.
- (3) The State Government shall allocate necessary funds for the purpose of reimbursement of the expenses incurred by those referred to in sub-section (1),
- (4) The scheme framed under sub-section (1) and subsequent changes, if any, made thereto from time to time, shall be published in the Gazette of the State Government.

**Penalties**

11. (1) Any person managing or responsible for the management of the hospital or a medical practitioner or agency running an ambulance or owner or operator of a vehicle which or who refuses to perform all or any of the duties referred to in sections 3 to 9, without justifiable reason, shall be liable for punishment by way of imprisonment for a period which may extend upto six months or for fine which may extend upto rupees ten thousand or for both.
- (2) Any hospital refusing to perform the duties referred to in sections 3 to 9 without justifiable reason, may be proceeded against for suspension or cancellation of any of its licenses under which it is running the hospital, in addition to the penalty referred to in sub-section (1) that may be imposed on the persons owning or managing the hospital.
- (3) Any medical practitioner attached to a hospital or any other medical practitioner who refuses to perform the duties referred to in sections 3 to 9, without justifiable reason may, in addition to the penalty provided in sub-section (1), be subjected to such disciplinary action as may be determined by the State Medical Council.
- (4) These provisions will be in addition to the penalties prescribed under any other law in force.

**Rule making powers**

12. (1) The State Governments may make rules for the purpose of enforcement of the provisions of this Act and publish the same in the State Gazette.

- (2) The rules referred to in sub-section (1) shall be laid before the legislature within a period of one month from the date of publication of the rules in the State Gazette as stated in sub-section (1).