MEDICAL NEGLIGENCE: NATURE AND SCOPE

Negligence in medical treatment is no different in law from negligence in any other field. The criteria’s and rules are the same, whether for liability, for causation or for compensation. At one point of time, there had been aberration when Lord Denning said that a ‘charge of negligence against a medical man was so serious. It is unlike charge of negligence against the driver of a motor car. Consequences are disaster as it affects the professional status and reputation and burden of proof is correspondingly greater.’ This proposition is clearly erroneous and no longer accepted as good proposition of law anywhere in the world. It follows therefore, the present chapter as an offshoot of the concept of negligence, it is appropriate to explore the nature and scope of negligence in general and negligence in the health care service.

Admittedly, the expression ‘medical negligence’ is difficult to analyse. Negligence in medical treatment or surgical operation always relates to a particular fact-situation, and what is decided in one case is usually little help or may not help in deciding subsequent disputes. It is also very hard to predict the outcome of the negligence in particular proving the case because of uncertainties surrounding the evidence and findings of fact. The ingredients of the negligence are a ‘duty of care’ owed in a particular situation by the health carer to the plaintiff, a ‘failure to discharge the standard of care’ required by the duty and a ‘loss’ occasioned thereby to the patient that is recognised by the law and loss or damage foreseeable at the time of the wrongful act and deemed by the law to have been caused by that act. The court will be having wide discretionary power in deciding the issue of medical negligence.

3. 1. Negligence in Law and in Common Parlance:

The word ‘negligence’ may be used in different ways. Negligence may mean ‘careless’ but this is not a legal meaning. Careless is a common meaning based on the experience. It cannot be accepted as the precise and appropriate meaning of the term negligence because what is negligence in common parlance may fall short of negligence at law. In law ‘negligence’ and ‘duty’ go together, two are correlative to each other. If one is to be attributed as negligence, he must owe duty to another. In
the absence of legal duty, there can be no negligence in the legal sense and no legal consequences too, although it may be negligence in the popular sense\(^1\).

### 3.1.1. Negligence: Meaning of

150 years ago Lord Baron Alderson said\(^2\): “Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do or doing something which a prudent and reasonable man would not do”. This definition raises question as to “reasonable man” and test to determine a person as reasonable man. It cannot be viewed as a precise meaning in terms of law as the concept of the ‘duty of care’ has not been referred. Mere negligence in itself does not give a cause of action. To give a cause of action, there must negligence which amounts to a breach of duty towards the person alleging negligence. A definition without covering a ‘duty of care’ does not serve as useful definition. However, definition cannot be rejected as a whole as irrelevant since it may be used in non-medical negligence cases.

It is attempted to define as either subjectively a careless ‘state of mind’ or objectively careless ‘conducts\(^3\).’ It is absolutely based upon the theory of negligence which emphasises the ‘will’ and ‘interest’ element of the actor. Neither the will nor interest theory enjoys the universal support. Each theory argues contrary to one another and suffers from its own lacunae besides ignoring the duty of care. By this definition, the court mean to say that negligence may be a mental attitude of undue indifference or it is a type of conduct\(^4\). It is not absolute term but it is a relative one, it is rather comprehensive term. No absolute standard can be fixed and no mathematically exact formula can be laid down by which negligence or lack care can be measured in a given case\(^5\). What constitutes negligence varies according to facts and circumstance of the case. In determining whether negligence exists or no in a particular case or whether a particular act or course conduct amounts to negligence all

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3 New India Assurance Company Limited Vs Ashok Kumar Acharya, 1994(92) TAC 464 at 467 (orissa).
surrounding facts and circumstances have to be taken into account. In determining whether an act would or would not be negligent, relevant point to consider is whether any reasonable man would foresee that act would cause damage or not. If answer is in the affirmative, it is negligent act.\(^6\)

A still and accurate definition covering ingredient in law can be given as follows: “Negligence is the breach of a legal duty of care owed to the plaintiff by the defendant whereby the plaintiff suffers damage.”\(^7\) It is called actionable negligence, which must involve a legal duty to act with reasonable care, a failure by act or omission, to discharge that duty and the loss occasioned by that failure, which proximate to the breach recognised by the law. In other words, negligence is failure to do duty resulting in injury or damage to other side.\(^8\) Duty means duty of care or duty to take care. The failure of duty to take care which causes injury is negligence.

### 3.1.2. Negligence: What signifies?

A type of conduct: There are two divergent view which explains or deals with the significance of negligence. Firstly, Prof. Winfield argues that negligence usually signifies total or partial inadvertence of the wrong doer towards his conduct or consequences of his conduct. Only in exceptional cases full advertence will be present with regard to both the conduct and consequences.\(^9\) In this context, negligence excludes intention. There is no desire for the consequences. Undesired consequences are the touchstone to distinguish negligence from intention. Negligence signifies as a tort is ‘the breach of legal duty to take care which results in damages, undesired by the defendant to the plaintiff’.\(^10\) Negligence is usually accompanied by inadvertence i.e., the wrongdoer does not intentionally cause the harm and never intends to bring about the desired consequences but exposes others to the risk of it. We can draw the distinction between negligence and intention.\(^11\) Negligence is a type of conduct, not a state of mind, not a fault or moral blameworthiness.\(^12\)

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\(^6\) Ibid.
\(^8\) Jay Laxmi Salt Works (P) Vs State of Gujarat 1995(1) PLR 1 (SC); (1995)1 LW41; (1995)1 Guj LR.
\(^10\) Ibid p 28
\(^12\) Working ton Dock and Harbour Board Vs SS Towerfield (owners) (1951) AC 112, 160
Accordingly, when one uses the word negligence, it implies ‘absence of intention to cause the harm complained of’\textsuperscript{13}. It is not mere a conduct, but it is an unreasonable conduct as to the consequences of one’s act\textsuperscript{14}. JS Colyer points out that the word ‘negligence’ may be used in two senses. First, it is the name of a tort where the injured brings a suit against the wrong-doer for damages. Secondly, negligence itself is sometime ingredient of other torts. Negligence, therefore, is a tort as well as a concept of the law of torts\textsuperscript{15}.

A state of mind: Secondly, Austin and Salmond argue that negligence is a state of mind, not a conduct\textsuperscript{16}. Negligence is a mental condition which should be penalised by damages. Austin identifies different states of mind as rashness, needless, or careless\textsuperscript{17}. However, commentator criticises the Austin’s concept of negligence as criminalist type of negligence. The different states of mind have no place in the modern law of torts which take into account only the external conduct of wrong-doer\textsuperscript{18}. Therefore, negligence in the proper sense denotes “a conduct rather than mental attitude”\textsuperscript{19}. Negligence as a type of conduct presupposes a duty of care. The idea of negligence and duty are correlative. If negligence were a mental attitude it would be difficult to identify the existence of duty. The court has emphasised the idea of duty on the part of the wrong-doer. A person is not negligent if owes no duty towards someone\textsuperscript{20}. In Donoughe Vs Stevenson, Lord Atkin observed: a man cannot be charged with negligence if he has no obligation to exercise diligence\textsuperscript{21}. A mere fact that a man is injured by another’s act does not give rise cause of action. The issue of negligence will not arise unless there is duty to exercise care\textsuperscript{22}.

\textsuperscript{13} See Radcliffe Vs Barnard (1870) LR 6 Ch. 654; Dixon Vs Muckleston (1872) LR 8 ch. 155; R Vs Senior, (1899) I QB 283.
\textsuperscript{16} Sir John Salmond defines, negligence as “mental attitude of undue indifference with respect to one’s conduct and its consequence” supra n 4.
\textsuperscript{17} Supra N. 14.
\textsuperscript{18} Supra N. 14.
\textsuperscript{20} Lievre Vs Gould (1893)1 QB 491.
\textsuperscript{21} (1932) AC 562.
\textsuperscript{22} Grant Vs Australian Knitting Mills (1936) AC 86.
3.1.3. Nature of Negligence:

It confronts some question, is negligence state of mind or conduct? What is really meant by the expression “state mind and conduct”? In resolving ‘state of mind and conduct’ problem, it is necessary to take into consideration individual elements like ignorance, stupidity, bad judgment, timidity, excitability or forgetfulness, age, inadequate or superior experience, fatigue etc.. Is negligence subjective or objective? It is contended that ‘subjective and objective’ are useful terms and assumes substantial significance in criminal law. This distinction is not only formal but materially also can be questioned in the criminal law. ‘Mensrea’ is commonly referred to as a subjective requisite while conduct is an objective one. This distinction seems to be based on obsolete apprehension of the separation of soul and body. The content of the ‘subjective’ requisite is above all determined by an ‘objective’ comparison between the act in question and community accepted standards, whether in making comparison, the individual characteristics should be taken into consideration is often referred to as ‘subjective and objective’ issue. The use of these terms creates confusion.

Salmond who is an exponent of state of mind theory draws distinction between negligence and intention. Each involve mental attitude of the actor/doer towards the consequences of the act. He is guilty of negligence when he does not desire the consequences and does act in order to produce them nevertheless due to careless or indifferent they may happen. Thus, careless man is he who does not care-who is not anxious that his activities may cause loss to others. On the other hand, wilful or intentional wrong doer is one who desires to bring out the desired result. Therefore, negligence and wrongful intention are mutually inconsistent and mutually exclusive state of mind. This Salmond viewpoint is attacked by Holmes, Roscoe Pound, Edgerton who consider mental theory as erroneous. Negligence does not involve or presupposes indifference or inadvertence or any other mental characteristic, quality, state or process. For Edgerton, negligence is unreasonably dangerous conduct.

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24 Ibid.  
25 Supra note 11 at 226.  
26 Supra N 4, at 389-390.  
28 Ibid.
3.1.4. Theories of Negligence: will and interest

One can notice the emergence of two theories such as ‘mental theory and conduct theory’. For proponents of the conduct theory negligence means unreasonably or abnormally dangerous conduct\(^{29}\). If then, negligence is deemed to be unreasonably dangerous conduct; it raises the question what is meant by ‘conduct’? The question seems more troublesome than it need to be. Because the state of mind has no relevance whatsoever in determining the conduct. A conduct becomes negligence, only when there are unreasonably dangerous motions or behaviour and not otherwise. It takes into account external elements and totally excludes the mental view of the perpetrator. It is immaterial to consider mental shortcoming such as ignorance, stupidity, bad judgment, timidity etc., which produce the mental act\(^{30}\).

Another line argument is the conduct theory is relevant within the realm of law torts and mental or state of mind theory assumes significance in the criminal law\(^{31}\). For the act to constitute a crime of negligence, however, an additional element, guilt is to be established\(^{32}\). According to Prof. Hart HLA the nature of negligence needs to be considered in determining the criminal liability for negligence. For this purpose, he suggests a ‘two way’ technique:

a) Did the accused fail to take those precautions which any reasonable man with normal capacities would have taken in the circumstances;

b) Could the accused, given his mental and physical capacities have taken those precautions?

The first question asks whether the actor has deviated from an ‘invariant’ standard of care, while the second takes into consideration the ‘individualised condition of liability’. However, in suggesting this approach, it should be noticed that Hart repudiates the theory of objective liability. Nonetheless, Hart’s approach has influenced American law\(^{33}\).

\(^{29}\) Supra 23.

\(^{30}\) Ibid.

\(^{31}\) Ibid.

\(^{32}\) Ibid at 131.

\(^{33}\) Ibid.
3.1.5. **Components of Negligence:** Duty, Breach and Damage

In law to constitute negligence, it must possess the following three conditions:

a) that the defendant owes to the plaintiff a legal duty to exercise care;

b) that the defendant was in ‘breach’ of that duty that is failure to exercise that the duty of care’ and

c) that as a result of breach, the plaintiff suffered damage.

Thus, in strict legal analysis, ‘negligence’ means more than needless or careless conduct, whether in omission or commission. It connotes the complex concept of duty, breach and damage suffered by the person to whom the duty owed.\(^\text{34}\)

### 3.1.5.1. Duty of Care:

In law, there is no negligence unless there is in the particular case a ‘duty to take care’. The duty of care is an essential element in civil wrong.\(^\text{35}\) Law does not take cognisance of carelessness in the abstract. It concerns itself only when there is a duty to take care and where failure of that duty has caused damage.\(^\text{35}\) The duty signifies that one must not interfere with the lawful act of another.\(^\text{37}\) The duty of care performs two distinct functions. Firstly, if the claimant is to succeed, it must be proved that the circumstances in which his damage or loss was caused were capable of give rise a duty of care and secondly, the defendant actually owed him a duty on the particular facts of the case. The first requirement raises question of law while the second raises questions of mixed law and fact.\(^\text{38}\)

a) **Idea of Duty:** The duty is not the sole factor to decide the question of negligence, it has to be decided on some other grounds such as contributory negligence, remoteness of damage, inevitable accident, violenti-non-fit injuria.\(^\text{39}\) The critique states there are limits of action of negligence, which are nothing to do with the things referred above.\(^\text{40}\)

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\(^{34}\) Lochegelly Iron and Coal Company Vs. Mullan, 1934, AC 1, per se Lord Wright.

\(^{35}\) Supra note 9.

\(^{36}\) Supra note 21.

\(^{37}\) Supra note 9.

\(^{38}\) Ibid.

\(^{39}\) Ibid at 46.

\(^{40}\) Lawson, Negligence in the Civil Law, (1947) 22 Tulane L.Rev. 32-36.
b) **Criteria of duty**: The question how to determine there is or is not, a duty? It is suggested that the task of the court is to follow the established precedent\(^ {41}\). What is the alternative way of deciding the notion of duty, in the absence of relevant precedent? Under this situation, the court has to examine the circumstances which warrant the existence of duty to be careful\(^ {42}\). Is it the general rule of law? It can be seen the first attempt to formulate a principle made by **Lord Brett** MR in Heaven Vs Pender\(^ {43}\) and **Lord Atkin** in Donoughe Vs Stevenson\(^ {44}\) that it is a ‘right of every injured person to demand relief’. This rule implies that every one must take reasonable care to avoid acts or omissions which he can reasonably foresee would be likely to injure his neighbour. Neighbour is one who is so closely and directly affected by another’s act, this rule is what is known as principle of “neighbour”.

\(^{41}\) Ibid at p. 46.

\(^{42}\) Pollock F, Torts 11\(^{th}\) edition, Oxford University Press 1967, p. 455

\(^{43}\) (1883)11 QBD 503, 509.

\(^{44}\) Supra note 21.

\(^{45}\) Ibid.

\(^{46}\) Woods Vs. Duncan (1946) AC 401.

\(^{47}\) Supra note 9.

\(^{48}\) Supra 19 p. 14.

c) **Duty towards whom**: It is not enough to prove circumstances which give rise to a notion of duty, it is also necessary to establish that defendant owed a duty of care towards him. The test for the existence of a duty owed to the person is in substance, ‘neighbouring principle’ that is foresight of the reasonable man\(^ {45}\). For this purpose all circumstances must be taken into account including the sequence of events leading to the accidents\(^ {46}\). It ia not mere sufficient to prove that the injury to the claimant would have been foreseeable and it is also not required that injured should necessarily be identifiable by the defendant\(^ {47}\).

### 3.1.5.2. Breach of Duty:

Generally, there is a duty on the part of everyone not to harm others. It does not mean there is a general duty to take care of others, for instance, one need not to take care of starving man, destitute, one need not to rescue or save a sinking man in the water, one need not to help a person in distress\(^ {48}\). A man is not answerable to others, if there is mere omission. But where there is an antecedent relation which
imposes a duty to take care towards another, omission to take care that result in injury constitute ‘negligence’ or actionable wrong’. Apart from contract, the duty to take care arises from the voluntary conduct of the party. Therefore, any person who undertakes to do something must use a reasonable care and caution to guard against the risk which is likely to cause harm or injury to others.

a) **Standard of Care: Reasonable man**

The test for deciding whether there has been breach of duty to take care would be the standard of an ordinarily careful man; it is not the foresight and caution of a particular man, who is capable of, but the foresight and caution of a prudent and reasonable man. In otherwords, the standard of care required by law is that of the reasonable man. It does not depend on the personal judgment of the defendant, nor does the law require that he must exercise highest degree of care which the human nature is capable of.

The English law of negligence differs from Roman Law that recognises different standard of negligence such as ‘gross’, ‘ordinary’ or ‘slight’. The question whether the defendant was negligent, will be determined with reference to single, invariable standard that is the ‘standard of reasonable man’. In this sense, negligence is defined as the omission to do something which a reasonable man, guided upon those consideration which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do. It is not clear whether the proposition defines the negligence concept or lays down the criteria to determine the standard of care.

b) **Reasonableness and Reasonable man: Characteristics**

Winfield says that reasonable conduct means the behaviour of the ordinary man in any particular event or transaction. Lord Bowen visualises the reasonable man as ‘the man on the clamphan omnibus’. It means the one who ‘protects others

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49 Ibid.
50 Supra note 7 at p. 153.
52 Supra note 2 p. 984.
53 Supra note 9 at p. 26.
54 Hall Vs Brooklands Auto Racing Club (1933)1 KB 205, 224, per se Greer L.J.
rather than the average man’ in the customary society. For Lord Romer, he has not the courage of Achilles, the wisdom of Ulysses or the strength of Hercules, nor has he prophetic vision of a clairvoyant\textsuperscript{55}. He will not anticipate folly in all its forms but he never puts out of consideration the teachings of experience and so will guard against negligence of others when experience shows such negligence to be common\textsuperscript{56}. He is a reasonable man but he is neither a perfect citizen nor a “paragon of circumspection”\textsuperscript{57}.

However, so far as professional service is concerned a person to be a reasonable man, has to exhibit certain amount of skill or competence which is usually associated with the efficient discharge of service\textsuperscript{58}. The man on the Clapham omnibus cannot be expected to have skill as a surgeon, a lawyer, chartered accountant, if he professes to be one, then the law required him to show such skill as an ordinary member of the profession or calling to which he belongs\textsuperscript{59}. The description of ‘reasonable’ cannot be given sufficiently, how a man behaves as a reasonable man depends on the facts-situation for instance if the law gives a special direction for the guidance of the ordinary man, he must regulate his conduct by them, then only he will be regarded as reasonable man.

c) **Nature of Standard:** Objective and impersonal

It is pointed out that standard of reasonableness eliminates personal equation and personal characteristic or qualities of the person whose conduct is in question. The Standard is objective and impersonal. What is material is not how the best he has acted in the particular situation, but whether he has acted as reasonable man. A reasonable man is presumed to be free from both over-apprehension and from over-confidence\textsuperscript{60}, maintain calm, collects information and remembers to take precautions

\textsuperscript{55} Hawkins Vs Coulsdon and purely U.D.C. (1954) 1 QB 319, 341 Lord Bramwell occasionally attributed to the reasonable man the agility of an acrobat and the foresight of a Hebrew prophet.

\textsuperscript{56} L.P.T.B Vs Upson (1949) A.C. 155, 173 per Lord Uthwatt; 176, Lord Pareq; Lang Vs London Transport Executive (1959) 1 WLR 1168, 1175, per Havers J.

\textsuperscript{57} AC Billings and sons Limited Vs Riden (1958) AC 241, 255, per Lord Reid. For a brilliant caricature of “this excellent but odious creature” see Alan Herbert Uncommon Law, pp 1-5, Eldred, Modern Tort Problems, p-3, “the reasonableman is fiction- he is the personification of the court and jury’s social judgment

\textsuperscript{58} Mutual Life and Citizens Assurance Company Limited Vs Evatt (1971) 2 WLR 23, 29-32.

\textsuperscript{59} Supra note 46.

\textsuperscript{60} Glasgow Corporation Vs Muir (1943) AC 448, 457.
against obvious dangers but, he takes the guard against reasonable probabilities, and not against fantastic possibilities. However, the standard leaves the judge to decide what, in the circumstances of the particular case, the reasonable man would have done and what accordingly ought to have foreseen and will not eliminate personality of the judge.

d) **Degree of Care and Skill:** Varies with likelihood of harm

The degree of care that constitutes negligence varies with the circumstance although the standard is the same. The amount of care will be different in different cases. It is said a reasonable man will not show the same amount of care when handling umbrella as when handling a loaded gun.

In case of a person who has engaged in a professional service, law expects him to exhibit the ‘average amount of competence’ which is required for the proper discharge of duties of that profession, calling or trade. If he falls short of that and injures someone in consequence, he is not behaving reasonably. Law does not demand the highest degree of care and skill, rather requires the competence as ordinary competent man. For example, a passerby who, while going renders emergency first aid after an accident, is not required to show the skill of a qualified surgeon. A woman, who does the small job of repair household, need not show the degree of skill which may be required for professional. The degree of skill required is the skill of a reasonably competent person doing the same profession.

Similarly, a surgeon is required to exhibit the care of a reasonably competent medical men in the field/art. If he has greater than average knowledge of the skill, he may be obliged to take more than average precaution. He has to possess reasonably the knowledge and skill upto date and cannot do obstinately and pig-

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61 Ghanan Vs Glasgrow Corporation, 1959, SC 23.
62 Fardon Vs Harcourt –Rivington (1932) 146 LT 391 (HL).
63 Supra note 59.
64 Caswell Vs Powell (1940) AC 152.
65 Beckett Vs Newalls Insulation Company Limited (1953)1 WLR 8, 17.
66 Supra 59.
67 Philips Vs Whiteley (1938) All ER 566.
68 Stokes Vs Guest, Keen and Nettleforld (1968) 1 WLR 1776 at 1788.
heartedly with the same old technique\textsuperscript{69}. But a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment\textsuperscript{70}. In \textit{Roe Vs Minister of Health}\textsuperscript{71}, a surgeon administered a spinal anaesthetic to the patient as precaution for minor operation. Unfortunately, some of the phenol which had been kept for use entered through ‘invisible crack’ into the ampoule. Thus, it contaminated anaesthetic; with the result that patient became permanently paralysed from the waist down. If the doctor was aware of the consequences of injecting phenol, he would have physically examined the ampoule before administering the anaesthetic, but he was not aware of the possibility of ‘invisible cracks’. Had he been aware of this possibility, the danger to the patient could have been eliminated by adding some powerful colouring agent to the phenol so that contamination of the anaesthetic could have been avoided. It was held that the doctor was not negligent.

The critiques point out that only the advantage of reasonable foresight is that it keeps in touch with the needs of the ordinary man. Whereas in a complex society ordinary men will have little knowledge or experience, so, they may not be equipped with the standard of care\textsuperscript{72}, besides being no clear guidelines as to identify the standards of reasonable man. As a consequence it will be very difficult to comply with the test reasonableness. Similarly, the degree of care varies with the change of situation in which case it confuses in reaching at the proper judgment.

e) **Standard of Care:** The concept of risk

It has also been argued that the standard of care in any particular case can be explained more better way in terms of risk rather than in terms reasonable foreseeability\textsuperscript{73}. A risk is a chance of harm to others which involved in the act in question. In view of this, there has been attempt to define negligence as a conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm.

\textsuperscript{69} Hunter Vs Hanley, 1955 SLT 213.
\textsuperscript{70} Barnett Vs Chelsea and Kensington Hospital Management Committee (1969) 1 QB 428
\textsuperscript{71} (1954)2 QB 66.
\textsuperscript{72} Supra
\textsuperscript{73} Ibid.
There are three factors to be taken into consideration such as a) the magnitude of the risk which defendant exposes other persons by his action; b) the importance of object to be achieved by the dangerous form of activity and c) the burden of adequate protection.

a) Magnitude of the risk: The degree of care depends upon the risk involved in the act. The magnitude of a risk can be determined with the help of two factors namely seriousness or gravity of the injury risked and the likelihood of injury being in fact caused. The relevance of seriousness of the injury was recognised by the House of Lord in *Paris Vs Stepney Borough Council* 74, the plaintiff who had only one good eye was blinded in the course of his employment. He contended, he was entitled to the remedy because the employer did not provide him with a goggle which was in breach of his duty to take reasonable care of his safety. It was observed that goggle should have been provided as the plaintiff risked the greater injury of total blindness. As a reasonable and prudent employer, the defendant would have known not only probability of an accident but also the gravity of the consequences if an accident did occur.

In addition to seriousness of injury, the likelihood of injury should be considered in measuring/evaluating magnitude of the risk. If the likelihood of injury to a person is so slight, failure to take precaution against the injury would not be breach of duty. In *Bolton Vs Stone* 75, the plaintiff was standing on the highway road adjoining to cricket ground when she was struck by a ball which had hit out of the ground, such an event was foreseeable as it happened on three occasions. Nevertheless, taking into account such factors as the distance from the pitch to the edge of the ground, the presence of a seven foot fence and upward slope of the ground in the direction in which the ball was struck, the House of Lord considered that the likelihood of injury to a person in the plaintiff position was so slight, and allowing cricket to be played without having taken additional precautions such as increasing the height of the fence, was not negligent 76.

74 (1951) AC 367.
75 (1951) AC 850, 886-889, per Radcliff LJ.
76 Ibid.
Thus, in assessing the magnitude of the risk, it is important to notice that duty of care is owed to the plaintiff himself and the injury which exposes risk to the plaintiff, should be known to the defendant. If it is unknown and not reasonably known to the defendant, then it is irrelevant.

b) The importance of the object to be achieved: It is also necessary to balance the risk against the consequences of not taking it. The standard to be adopted must serve or justify the object to be attained. In Daborn Vs Bath Tramways\textsuperscript{77}, it was opined that left hand drive ambulance during emergency period of war was not negligent in turning right without giving a signal.

c) Practicability of Precautions: The risk has to be weighed against the measures which are required to eliminate it and the practical measures which the defendant has taken, must be considered\textsuperscript{78}. In \textit{Mc Carthy Vs Coldair Limited}\textsuperscript{79}, a factory became slippery due to a flood. The owner took average possible measure to remove the effect of the flood; nevertheless, the plaintiff was injured who contended that the owner should have closed down the factory. The House of Lords held that the risk of injury created by the slippery floor was not so great to take greater the precaution.

3.1.5.3. Consequential Damage:

The third component of the tort of negligence is the claimant’s damage must have been caused by the defendant’s breach of duty and must not be too remote a consequence of it\textsuperscript{80}. In case of breach of contractual duty, the amount of damage will be assessed from the breach itself; in case of breach of duty not founded on contract, the plaintiff has to prove that damage has been caused to his person or property\textsuperscript{81}. It is also necessary to prove that negligent act of the defendant is the “direct and proximate” cause of the damage. If the causal connection between the negligent act and damage is not direct, the damage is too remote; there is no remedy at law. The defendant is not guilty of breach of duty, when he has taken reasonable care as every

\textsuperscript{77} Daborn Vs Bath Tramways (1946(2 All.ER 333 at p 336.
\textsuperscript{78} (1965) AC 778.
\textsuperscript{79} (1951) 2 TLR 1126
\textsuperscript{80} Supra 46 at p. 83.
\textsuperscript{81} Supra 71.
one is expected to take, the damage would have occurred. In such a case, plaintiff is not entitled to any remedy.\textsuperscript{82}

\section*{3.2. THE PHYSICIAN – PATIENT RELATIONSHIP}

The first and foremost issue in medicine touched by the law is the relationship between the physician and the patient. The legal rights and duties of the health care providers and patients are founded upon the sanctity of the physician and patient relationship. Though the reference to the duties of the physicians can be found in ancient \textit{Hanurami code} (1792-1750 BC), still the courts and the alternative adjudicators use the physician-patient relationship as the paradigm for the emergence of the legal rights and responsibilities between health care providers and patients. However, at this juncture, it is not clear how much of the law developed for the physician-patientship will be applied to the health care providers. It is also difficult to predict which direction the law is moving. There is also some overlap between the physician-patient and the hospital-patient relationship, but they are not similar. Sometimes when the hospital care is required, physician will not establish the hospital-patient relationship since; the physician does not have admitting privilege. In some emergency cases, the relationship with the hospital may begin before the relationship with the physician. Sometimes a patient may change physicians while in the hospital, creating a new physician patient relationship. Many a time, after the relationship with the hospital ends, the physician-patient relationship continues. Nonetheless, the doctor-patient relationship forms the cornerstone of the legal implications emerging from the medical practice. Hence, it is important to focus on the modalities of a doctor-patient relationship in order to study the relevant concepts of informed consent, confidentiality and negligence.

Traditionally, the physician-patient relationship is fiduciary relationship. The patient reposes trust and confidence in the doctor by submitting himself under the care of the doctor without apprehension of life. The obligation of the doctor is to do good to the welfare of patient. Under no circumstances, the doctor should cause harm to the patient. He is governed by the doctrines of ethics such as beneficence, non-malefeasance and paternalism. With the globalisation of medical care, the doctor-

\textsuperscript{82} Ibid p. 158.
patient has become complicated issue, the consideration or reward which was the last is today of the first consideration of the practitioners. Increasing litigation between the physicians and health care organisations, physicians and patients, shows that ‘absolute faith in the medical profession is more or less a thing of the past’. The WHO document brings in vital changes in the traditional relationship of the doctor and patient. The physician-patient relationship was defined primarily by the rules of medical ethics. During the last two decades an approach to this relationship focusing on legal provisions has emerged. The concepts of ‘autonomy and self-determination’ are refining the relationship in terms of contract. The rights of patients emphasize the importance and meaning of negotiation and patient’s participation.

WHO document recognises the following principles for the fullest expression of human rights in health care.

a) Everyone has the right to respect of his or her as a human being;

b) Everyone has the right to self-determination;

c) Everyone has the right to physical and mental integrity and to the security of his or her person;

d) Everyone has the right to respect for his or her privacy;

e) Everyone has the right to have his or her moral and cultural values and religious and philosophical traditions respected;

f) Everyone has the right to such protection of health as is afforded by the appropriate measures for disease prevention.

The principles of patients’ rights are focusing on the beneficial relationship of doctor-patient relationship which encourage the participation of and respect for the patient and protects the patients’ dignity and integrity. It would also allow patients to obtain the fullest possible benefit from the health care system and encourage the wider dialogue between doctors/ health care providers and recipients.

84 Ibid p. 8.
85 Ibid p. 38.
In the context of the human rights, physician-patient relationship is contractual, as the care is offered by the medical man and accepted by the patient for consideration. Relationship exposes the doctor to duty of care, skill, diligence and knowledge, failing which attributes medical negligence. However, there are some criticisms against this, first medical care provided to the patient in National Health Service in England and hospitals owned and managed by the state are in pursuant to the statutory obligation or charitable basis, such service is considered to be inconsistent with a contractual arrangement. Secondly, the patient does not pay consideration in return for the service availed in the hospital. There is no contractual relationship between the patient and health care provider. Any claim for damages based upon a breach of duty of the doctor lies in tort for negligence. It is suggested that the patient’s submission to treatment constitute sufficient consideration for a contract. The consideration does not necessarily in terms of monetary.

3.2.1. Beginning of Relationship: To establish relationship with a patient is the privilege of the medical man. It is purely a voluntary. A medical man may accept or decline to establish relationship. A physician does not have a legal responsibility to diagnose or treat anyone unless there is an express or implied contract to do so. Likewise, an individual does not have an obligation to accept diagnosis or treatment from any particular physician unless the reasonable care is taken. This voluntariness permits the physician to make economic discrimination against patients. A physician has the professional liberty to refuse undertaking treatment if a patient is unable to pay for the required medical service. Some physicians refuse to treat patients involved in accidents that will lead to litigation. Some physicians refuse to treat lawyers as problematic. Many obstetricians refuse to treat a pregnant woman who first seeks care after the seven month of pregnancy. Within these restraints, the law

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88 Pfizer Corporation Vs Ministry of Health (1965) AC 52 (HL).
89 Roy Vs Kensington and Chelsea FPC (1992) 1 All.ER 705 (HL).
90 Kennedy Ian and Grubb Andrew, Principles of Medical Law, Oxford University Press p 286
91 Cogg Vs Bernard (11703) 92 ER 107.
92 Sala Vs Gamba, 760 S.W.2d 838 ( Tex. Ct. App. 1988).
94 Ibid at p. 177.
assumes that a physician must accept a patient voluntarily before the physician-patient relationship is legally binding\textsuperscript{95}.

\textbf{3.2.1.1. Contract to care for a certain people}: The obligation of the physician depends upon the terms and conditions of the contract. A physician may have a contract with hospitals/health management organisations to care for emergency patients or render certain services such as radiology or pathology. This contract does not permit the physician to refuse medical care to hospital patients\textsuperscript{96}. This type of contract will be made with health care organisations such as athletic teams, schools, companies, prisons and jails and nursing homes. The physician owes to patients a duty of reasonable care in that supervision\textsuperscript{97}.

\textbf{3.2.1.2. Explicitly Accepting the Patient}: It is the clearest way of forming a physician-patient relationship. The physician either by way of written contract or by word of mouth accepts the patient. Here, physician limits the scope of the contract and does not assume responsibility for all the patient’s medical needs say perform surgery\textsuperscript{98}, refuse to participate in home deliveries\textsuperscript{99} or limits the geographical area in which the physician practices\textsuperscript{100}. In \textit{Giallanza Vs Sand}, the physician agreed to treat the patient who a few days later died of an undiagnosed brain abscess. The physician never saw the patient. The court ruled that there was a physician-patient relationship that included a duty to see the patient, so the patient’s father could sue the physician for malpractice\textsuperscript{101}.

\textbf{3.2.1.3. Implied from the physician’s conduct}: Every time explicit agreement cannot be done, therefore, one way to trigger a physician-patient relationship is to evaluate patient’s medical condition, for instance, in an examining room, talking to

\textsuperscript{95} Reynolds Vs Decatur Menil Hospital, 660 N.E. 2d 235 (III App. 4 Dis. 1996)
\textsuperscript{96} Hongsathavij Vs Queen of Angels Hollywood Presbyterian Med. Ctr., 62 Cal. Appl 4\textsuperscript{th} 1123, 73 Cal. Repr. 2d 695 (2\textsuperscript{nd} Dist. 1998), Hospital Board removed physician from on-call panel after refusal to deliver high-risk patient in labor.
\textsuperscript{98} Skidje Vs Hardy, 47 Wash. 2d 557, 288 P. 2d 471 (1955).
\textsuperscript{99} Vidrine Vs Myes, 127 So 2d 809 (La. Ct. App. 1961)
\textsuperscript{100} McNamara Vs Emmons, 36 Cal. App. 2d 199, 76 P 2d 503 (4\textsuperscript{th} dist. 1939)
\textsuperscript{101} Giallanza Vs Sands (316 So, 2d 77 ( Fla. 4\textsuperscript{th} DCA 1975); Maltempo Vs Cuthbert, 504 F 2d 325 (5\textsuperscript{th} Cir. 19740) Physician liable for failure to examine jailed aptient after agreeing with his parents to do so even though patient was under care of jail physician.
him in an emergency ward, commencing treatment, the court will find a physician-patient relationship. The physician’s right to refuse to accept the patient is to be exercised before the doctor evaluate the patient and determines that the patient is in need of immediate care, then the physician is responsible for ensuring that necessary care is provided. If the patient is not in need of immediate care, the physician may terminate the relationship.

3.2.1.4. Exercising Independent Judgment: It is argued that a physician-patient relationship is formed when the physician exercise independent medical judgment on the patients behalf. However, it is a vague term as it has to be defined by the facts of the given situation. It may involve making a diagnosis, recommending treatment or implying that no treatment is necessary. As a legal concept, the key issue is: Did the patient reasonably rely on the physician’s judgment? A physician may exercise independent medical judgment explicitly or impliedly. The problems may arise from the implicit exercise of the medical judgment, since the physician is not aware of the physician-patient relationship.

3.2.1.5. Telephone and online calls: With the development of communication technology, telephone and online calls have become a leading mode of contacting physicians. By this technology, medical care has been able to extend to the area where access to medical care is too remote. Indeed, it poses the most difficult problem whether it effect the physician-patient relationship between the caller and the physician. Some patients call physicians for every minor medical problem and some patients call when they believe that they have a serious problem. From physician’s perspective such calls involve minor problems because if the case is so serious, the physician expects the patient to contact in person for the appropriate diagnosis. The situation gives rise to the physician to mishandle telephone calls by underestimating the severity of the patient’s condition. Yet, it has been held that telephone conversation, the video and computer based tele-medicine, establish the

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102 Robert D Miller JD, and Rebecca C. Hutton DD, Problems in Health Care Law, Aspen Publication, Maryland, 2000, p422
103 Supra note 92 p. 175.
104 Ibid.
105 Ibid.
professional relationship with the patient, at the primary level. The doctor is as obligated as the direct consultation. It is not clear, how the court adopts the criteria to determine reasonable duties of the physician.

3.2.1.6. Emergency Medical Care: In emergency cases where the patient struggles for life and death, there is no need to have pre-existing physician-patient relationship. In a historical judgment, the Supreme Court of India has called upon the medical professionals to extend emergency service to protect the life of injured with no delay on the pretext of the complying with the procedural requirements. If the physician whether at governmental hospital or otherwise, fails to extend immediate medical care, it amounts to negligence. Some commentators criticise that there is no legal duty on a medical practitioner to examine, treat or give aid to a stranger, whether in an emergency such as a road accident or otherwise. Therefore, he cannot be held liable in law for refusing or failing to treat or arrange for treatment of a person with whom he has not established professional relationship. Even if a police calls a doctor in an accident case, he may render first aid and advice and it does not give rise to professional relationship.

3.2.1.7. Obtaining a Consultation: One issue concerning physician-patient relationship is, whether obtaining a consultation from a specialist give rises professional relationship with the patient. The physician relies on the specialised consultants since consultation is also very useful in ascertaining the proper diagnosis of the patient. Does it change the responsibility of the original / primary physician for the patient’s care? In Sunil Rungta Vs Dr. Chandra Shekar Agarval, the patient whose condition is so serious gets admitted to the hospital for treatment. The junior doctor who is on duty informs the senior doctor over the telephone about the serious condition of the patient. The senior doctor who without visiting the hospital issues instruction according to which two bottles of blood and saline are administered under the supervision of the junior doctor. The next time during the visiting hours the senior

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107 Paramananda Katara Vs Union of India (1989) ACJ 1000 (SC)
108 Supra note 92 p. 180.
110 Ibid p. 108.
111 III (2002) CPJ 266.
doctor suggests some pathological tests. But the pathologist fails to collect the sample, and by the time the pathology staff collects the samples of urine and blood, the patient dies. The court termed the conduct of the senior doctor and pathologists as negligence and held them responsible to the death of the patient. If the consultant misleads the physician by wrong reports, the consultant will be liable to the patient\textsuperscript{112}. Hence, both the physician and consultants need to have mutual understanding and discuss the needs of the patient.

3.2.1.8. Expectation of continued treatment: Traditionally, once the physician accepts the patient, for treatment, it establishes invariably the professional relationship. The point is the extent of the physicians responsibility to continue the cure. Whether the patient has a reasonable expectation of continued treatment, or whether the physician explicitly terminates the relationship. The hospital has no obligation to admit a patient after providing proper emergency cure\textsuperscript{113}. If the hospital is not able to provide the needed care, it has a duty to continue care until the patient is transferred to another physician or releases from care\textsuperscript{114}. A physician is not bound to continue treating a patient who refuses the treatment\textsuperscript{115}.

3.3. INFORMED CONSENT

The validity of professional relationship and medical treatment rendered by the physician can be challenged on the ground of informed consent. Health care providers must obtain appropriate authorisation before examining a patient or performing diagnostic or therapeutic procedures. If the patient is not competent adult, the consent of some other person or court with the authority to give or in the case of a child, the consent of the parent or guardian is necessary\textsuperscript{116}. Medical informed consent law requires the disclosure of the risks, alternatives to suggested medical procedures so as to enable patients to make knowledgeable decisions about the course of their medical care\textsuperscript{117}. When there is no consent or proper authorisation for a procedure, the


\textsuperscript{113} Harper Vs Baptist Hospital 341 2d 133 ( Ala. 1976)

\textsuperscript{114} Thompson Vs Suncity Comm. Hospital 141, Ariz, 597 p 2d 605 (1984)

\textsuperscript{115} Cruzan Vs Director, Missouri, Dept. of Health, 497 U.S. 261 (1990)

\textsuperscript{116} Francis Robert QC and Johnstone Christoper London: Butterworths, 2001 p 5

\textsuperscript{117} Merz JF., “ An Empitical Analysis of the Medical Informed Consent Doctrine: Search for a “Standard” of disclosure” cited at www.fplc.edu/RISK/Vol2/winter/merz.htm
physician or other practitioner doing the medical procedure can be liable for ‘battery’ even if the procedure is properly performed, is beneficial and has no negative effects\(^{118}\).

### 3.3.1. Justification of Informed Consent: Autonomy of patients

Since the Nuremberg trials consent has been discussed as one of the issues of bio-medical ethics. The terms ‘informed consent’ did not appear until a decade after the Nuremberg trials\(^{119}\) and it did not receive much importance until the early 1970’s. In recent years, the focus has shifted from the physician’s obligation to disclose information to the quality of a patient’s or subject’s understanding and consent. The reason behind this shift was the respect for autonomy of patients.

The early history that concerned about research experiments and informed consent shows that the informed consent had been used as a means to minimise the risk, avoiding unfairness and exploitation of the medical research institutions. Since the mid-1970’s the primary justification for focusing on the informed consent has been to protect autonomous choice of patients and research subjects\(^{120}\).

### 3.3.2. Meanings and Elements of Informed Consent:

There is a great deal of controversy over the idea of informed consent. Some commentators state that it is a mutual decision-making process between doctor and patient, so that informed consent and mutual decision-making are synonymous\(^{121}\). They do not agree with what the informed consent carries the meaning in ordinary language or law, rather attempt to argue that it should have the particular meaning. However, informed cannot be considered as to share decision-making as it is a

\(^{118}\) Fox Vs Smith 594, So. 2d 596 (Miss. 1992), removal of uterus would be battery after express direction not to remove; Bommarreddy Vs Superior Court, 222 Cal. App. 3d 1017, 272 Cal. Rptr. 246 (1990), punitive damages are allowed for battery, cataract performed when the consent only for tear duct surgery; Johnson Vs Mecurry, 461 So. 2d 775 (Ala. 1984) a different physician than the one to whom the consent was given carried out the procedure.


misleading concept, for example, a patient may have already decided in an informal manner what he wants prior to consult a health professional\textsuperscript{122}.

The concept of informed consent can be defined in two senses, namely, in terms of autonomous choice and social rules of consent. In the first sense, an informed consent is an individual’s autonomous permission about a medical intervention or participation in research. It is something more than express agreement or complying with a proposal. He permits through the act of voluntary consent. In the classic case of Mohr Vs Williams\textsuperscript{123}, a physician obtains consent of one Anna Mohr to perform an operation on her right ear. By mistake, the surgeon operates on the left ear. The action of the surgeon was challenged on the ground that the physician should have obtained patient’s consent to the surgery on the left ear. The court viewed that ‘if a physician advises a patient to submit to a particular operation, and the patient weighs the dangers and risks incident to its performance and finally consents which in effect authorises the physician to operate to the extent of the consent given, it is said to be informed consent.’ An informed consent occurs in this context only when the patient or subject understands clearly without the control by other, intentionally authorises a health professional to do something and not otherwise.

In the second sense, informed consent may be analysed in terms of the social rules of consent in institutions. Health institutions obtain legally valid consent from patients or subjects before proceeding with diagnostic, therapeutic or research procedures. Informed consent is not necessarily autonomous act under these rules and sometimes it is not meaningful authorisation. Yet informed consent is called institutionally effective authorisation\textsuperscript{124}. The critique says obtaining consent under the hospital rules cannot be termed as bonfide informed consent, since, a physician who obtains consent under this form fails to meet the required standards of an autonomous based model\textsuperscript{125}. Some other argues that institutional rules cannot be rejected as superficial, in fact, consent obtained under institutional rules will be

\textsuperscript{122} Supra 118 p. 78.
\textsuperscript{123} 95 Minn. 261, 265; 104 N.W.12, 15 (1905)
\textsuperscript{124} Supra 121.
difficult or even impossible to implement and the burden of proof lies on the hospital.  

3.3.3. Elements of Informed Consent:

Mainly, there are two elements such as ‘information’ and ‘consent’. The former refers to disclosure of information and the latter refers to voluntary decision and an authorisation to proceed. But, according to legal and medical literature, the following may be cited as the components of informed consent: a) competence; b) disclosure; c) understanding; and d) voluntariness. These four elements focus on the obligation to make disclosure in terms of informed consent.  

3.3.3.1. Competence: Competence of patients and potential subjects is very much relevance in determining a valid consent. Some commentators distinguish judgments of capacity judgment of capacity from judgments of competence on the grounds that health professional assess capacity and incapacity, whereas courts determine competence and incompetence. However, Thomas Grisso and Paul Applebaum reject the distinction in practice by stating that when professionals determine that a patient lacks decision-making capacity, the practical consequences will be the same as those attending a legal determination of incompetence.  

3.3.3.2. Definition: There is lack acceptable definition of competence and a single standard of competence. One core meaning of the word ‘competence’ which applies in all contexts is “the ability to perform a task”. Criteria of competency varies context to context as they related to specific tasks, for instance a person who is incompetent to decide about financial affairs may be competent to take decision about the medical treatment. Therefore, competence depends not only on a person’s abilities but also on how that person’s abilities match the particular decision-making task he confronts. Contrast to the core meaning is presumption of law that a person

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126 Supra note 118 p.79.
who is incompetent to manage his estate is also incompetent to vote, make medical decisions, and the like. Such presumption is based upon the global experience, in *Pratt Vs Davies*\(^{130}\) a physician opines that a patient is incompetent to make decisions because of epilepsy, but many persons who suffer from epilepsy are competent. Such judgment defies what the people know about the etiology of various forms of incompetence.

### 3.3.3.3. Standard of competence:

The questions about competence often focus on standards for its determination that is the conditions which a competence judgment must satisfy. Standards of competence or capacities closely connected to the attributes of autonomous persons such as cognitive skills and independence of judgment. In medical contexts, a person is usually considered competent if he able to understand a therapeutic or research procedure, to deliberate regarding its major risks and benefits and to make a decision in light of this deliberation. If a person lacks any of these capacities, then his or her competence to decide, consent or refuse creates doubt about the informed consent.

The troublesome questions arise about how to classify persons who have lacked capacity to understand, deliberate, or decide and persons (patients) who have capacity to understand, deliberate and reach conclusions\(^{131}\). For example, some religious fanatics, although they have fictitious and delusional beliefs, have capacities to understand, deliberate and decide, yet they may not be able to take decision about the medical intervention. A patient who is influenced by religious faith may not be competent to take appropriate medical decision. Considering the rival standards of incompetence, the following may be cited as standards of competence\(^{132}\).

1. inability to express or communicate a preference or choice;
2. inability to understand one’s situation and its consequences;
3. inability to understand relevant information;
4. inability to give a rational reason;
5. inability to reach a reasonable decision.

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\(^{130}\) 118 Ill.App. 161 (1905), aff’d. 224 Ill. 300, 70 N.E. 562 (1906).


\(^{132}\) Supra n. 118 p 73.
These standards are used either alone or in combination, in order to determine incompetence. Garriso and Applebaum focus on four functional abilities in assessments of competence to consent to treatment: ability to express a choice; ability to understand information relevant to treatment decision-making; ability to appreciate the significance of that information for one’s own situation and ability to reach conclusion logically.  

3.3.4. Disclosure:

One of the general obligations of the physician to exercise reasonable care is to provide required information to the patient. From the legal viewpoint the failure of the physician complying with the obligation intentionally or negligently, attracts liability for any injury that results in as consequence. From the moral viewpoint, informed consent is less to do with the liability of physicians as agents of disclosure and it is more autonomous choices of patients. Nevertheless, professionals have to deliver information without which patients cannot involve in decision-making process. Professionals are generally obligated to disclose a core set of information including a) facts or descriptions that patients or subjects usually consider material in deciding whether to refuse or consent the proposed treatment, b) the information professional believes to be material, c) the professional recommendation, d) the purpose of seeking consent and e) the nature and limits of consent as an act of authorisation. If research is involved, disclosures should cover the aims and methods of the research, anticipated benefits and risks, any anticipated inconvenience or discomfort, and the subject’s right to withdraw without penalty from the research.

3.3.4.1. Standards of Disclosure: The courts in US have developed two important standards for determining whether disclosure is adequate: the professional practice standard and the reasonable person standard, beside, the subjective standard has also
received support. A claimant must show that breach of this standard caused the injury\(^{136}\).

3.3.4.2. The professional practice standard: This standard holds that the professional has a duty to make the disclosure a reasonable medical practitioner would make under the same or similar circumstances\(^{137}\). The professional custom establishes the amount and kinds of information to be disclosed. Disclosure like a treatment is a task that belongs to physicians because of their professional expertise and commitment to the patient’s welfare. As a consequence, expert evidence from members of this profession is required to prove whether the physician has violated a patient’s right to information.

This standard is called a ‘reasonable doctor standard’ which poses several difficulties; first, it is uncertain in many situations whether a customary standard exists for the communication of information in medicine. Second, if custom exists, can it be conclusive, whether professionals have discretion to determine the scope of disclosure. Third, it is also questionable whether many physicians have developed skills to determine the information in their patients’ best interests\(^{138}\). Finally, professional practice standard subverts the right of autonomous choice. Professional standards in medical care are required for medical judgments but decisions for or against medical cares which are non-medical decisions are the provinces of the patient.

3.3.4.3. The reasonable person standard: According to this standard, the court determines the information to be disclosed by reference to a ‘hypothetical reasonable person’. Whether information is pertinent or material is measured in terms of how a reasonable person decides as to adopt a procedure. Physicians may be found guilty of negligent disclosures, even if their behaviour conforms to recognised professional practice. However, the reasonable person’s standard encounters conceptual, moral

\(^{136}\) Supra 101, p. 452.


and practical difficulties. First, the concepts of “material information” and “reasonable person” have never been carefully defined. Second, questions arise about whether and how the reasonable person standard can be employed in practice. Its abstract and hypothetical character makes it difficult for physicians to disclose information.  

3.3.4.4. The Subjective Standard: This standard requires physicians to disclose information by reference to the specific informational needs of the individual person, rather than hypothetical “reasonable person”. Individual needs will differ because of beliefs and family historians that require different information than the reasonable person needs. If a physician knows or has reason to believe a person wants a particular information then withholding it undermines autonomy. The issue is the extent to which the information should be disclosed, is subjective. As a reasonable person, a physician has to know the patient’s informational needs. No expert testimony is required on the scope of disclosure, although expert testimony is generally necessary to prove the existence of risks and alternatives.  

The subjective standard is a sort of moral standard of disclosure since a physician alone determines what information a patient needs. Nevertheless, exclusive reliance on a subjective standard is not adequate in terms of law or ethics, and it is also very difficult to know what information would be relevant for deliberation.  

3.3.5. Exceptions to the disclosure Requirements:  

There are four exceptions to the disclosure requirement in circumstances where the consent must be obtained such as emergencies, the therapeutic privilege, patient waiver and prior patient knowledge.  

3.3.5.1. Emergencies: In an emergency, when there is no time to obtain consent, consent is implied. Where obtaining consent detrimentally delays proper

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139 Supra 118 p. 82.  
140 The Oklahoma Supreme Court has Supported this standard in Scott Vs Bradford, 606, P 2d 554 (Okla. 1979); Masquat Vs Maguire, 638 P 2d 1105, Okl. 1981; 139A. Hapchuck Vs Pierson, 201 W.Va. 216, 495 S.E. 2d 854 (Oct. 24, 1997).  
141 Hapchuck Vs Pierson, 201, W.va. 216, 495 S.E. 2nd 854 ( October 24, 1997).  
142 See generally, Meisel The “Exceptions” to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decision Making, 1979 WIS.L. Rev. 413; 487 (1979).
treatment\textsuperscript{144}, where there is time to obtain consent but inadequate time for the usual disclosure, an abbreviated disclosure is sufficient\textsuperscript{145}.

\subsection*{3.3.5.2. Therapeutic Privilege:} Under this privilege, the physician may withhold facts if he thinks that the disclosure poses a significant threat to patient or upsets or interference with treatment or adversely affect the condition or recovery of the patient\textsuperscript{146}. In some cases, it has been held that when the therapeutic privilege permits non-disclosure, the information must be disclosed to a relative and that relative must concur with the patient’s consent before the procedure may be performed\textsuperscript{147}. However, in one case, court ruled that relatives did not need to be informed of withheld information\textsuperscript{148}.

\subsection*{3.3.5.3. Patient Waiver:} A physician may withhold the disclosure of information at the instance of the patient. It is the autonomy of the patient to waive the privilege knowing the information\textsuperscript{149}. However, the court will be sceptical of waivers, because the prudent health providers will not suggest waivers, instead encourage reluctant patients to be informed. Similarly, a physician doesn’t need to reveal risks of which the patient is already aware or risks which are commonly known\textsuperscript{150}.

\subsection*{3.3.5.4. Understanding:} There is lack of consensus regarding the nature of understanding of information about diagnosis, procedures, risks and prognosis\textsuperscript{151}. Some patients and subjects may be eager to know whereas others may be nervous or block understanding. Lack of awareness, deprives a person’s understanding. In \textit{Bang Vs Miller Hospital}\textsuperscript{52}, patient is not interested to consent to a sterilisation entailed in prostate surgery, but gives consent to perform prostate surgery without understanding.

\begin{footnotesize}
\begin{enumerate}
\item Nicklaus Vs Bellina, 696 So. 2d 120 (La. Ct. App. 1997) where extention of tumour removal to hysterectomy justified by emergency during surgery.
\item Stafford Vs Lousiana State University, 448 So.2d 852 (La Ct. App. 1984)
\item Shinn Vs St. James Mercy Hospital 675 F. supp. 94 (W.E.N.Y. 1987); Crouch Vs most, 78 N.M. 406 P 2d 250 (1967).
\item Pardy Vs United States, 783 P 2d 710 (7th Cir. 1986)
\item Lester Vs Actna Casualty and Sur. Co., 240 F 2d 676 (5th Circ.)
\item Nishi Vs Hartwell, 52 Haw. 188, 296, 473 P 2d 116 (1970).
\item Wachter Vs United States, 877 F. 2d 257 (4th Cir. 1989); Ciarlariello Vs Schacter, (1993)2 SCR 119, patient undergoing second cerbral angiogram capable of consenting based on earlier disclosures, no duty to make new disclosures where no significant change in risks.
\item Barbara A Bernhardt, “Educating Patients about Cystic Fibrosis Carrier Screening in a Primary Care Setting”, Archives of Family Medicine 5(1996); 336-40
\item 251 Minn. 427, 88 N.W. 2d 186 (1958).
\end{enumerate}
\end{footnotesize}
the procedure involves sterilisation. Had he understood the procedure, he would not have consented for prostate surgery. It is therefore, argued that revelation of material fact leads patients to distort information and promote inferential errors and disproportionate fears of risks. However, such misconception prevents a person from adequately understanding the risk.

3.3.5.5. Voluntariness:

The patient’s consent must be voluntary. Voluntariness means the presence of adequate knowledge, the absence of psychological compulsion and the absence of external constraints\textsuperscript{153}. In this sense, voluntariness would be equivalent to the autonomous action. A person wills the action without under the control of another’s influence. But in medical treatment, a patient is not free from the influence of the physician. Therefore, the doctor instead of threat of abandonment, has to persuades the patient to undergo the procedure when the patient is at first reluctant to do so, through acts of love, education, suggestions and emotional appeals. Coercion occurs if one person intentionally uses a credible and severe threat of harm or force to control another\textsuperscript{154}. Coercion renders even intentional and well-informed behaviour non-autonomous.

3.3.6. What Constitutes Informed Consent

The principles forming the cornerstone of informed consent, are enumerated by Lord Scarman in the case of Sidaway Vs Board of Governors of Bethlehem Royal Hospital\textsuperscript{155}: a) an individual of adult and sound mind has a right to choose what shall happen to his or her body; b) informed consent enables the patient to exercise right of a choice and gives an opportunity to evaluate the options available and the risks attendant on each; and c) obligates the doctor to disclose all material risks.

The requirement of informed consent is an integral part of the patient’s autonomy of choice. The right to informed consent implies the right to refuse consent. Any person of adult and sound mind has capacity to refuse. The rules of


\textsuperscript{155} (1985)2 WLR 480.
consent are designed specifically to protect patients from manipulation and abuse by the physician in the guise of medical treatment. The physicians have responsibility to furnish adequate information to the patient before obtaining the consent. Any procedure or therapy undertaken by the doctor without the voluntary consent of the patient constitutes negligence. Therefore, in making treatment decision, appropriate weight should be given to the patient’s wishes. Patient wishes expressed should be considered. However, it does not mean, the doctor’s obligation is to carry out the wills and wishes of the patient. The doctor should not oblige to assist his patient’s death or administer drug or device prohibited by law or treatment against the professional ethics.

3.4. MEDICAL CONFIDENTIALITY

One of common law duties which are imposed on a doctor is respect the confidence of his patients\textsuperscript{156}. This obligation which applies to medical material extends to all confidential information\textsuperscript{157}. There is a public interest in the maintenance of confidences that law provide remedy for the breach of the obligation\textsuperscript{158}. The rule of confidentiality enhances the doctor-patient relationship. Without this rule, patient will not entrust full, potentially intimate, details to the doctor\textsuperscript{159}. However, patient need not tell the physician that information disclosed be kept confidential, the obligation arises out of the existence of the relationship. The doctor is under a duty not to reveals without the consent of the patient, information which he, the doctor, has gained in his professional capacity\textsuperscript{160}.

3.4.1. The Nature of Medical Confidentiality:

Confidentiality is a branch of informational privacy which prevents re-disclosure of information what was originally disclosed within a confidential relationship\textsuperscript{161}. The basic difference between the concepts is, an infringement of a

\textsuperscript{156} The doctor-patient and priest-penitent relationships were cited as classic examples in Stephens Vs Avery (1988) Ch. 449 at 455, (198802 All. ER 477 at 482, per Brone-Wilknison V-C.

\textsuperscript{157} A.G Vs Guardian Newspapers Limited (No.2) (1990) AC 109, (1988)3 All ER 545.

\textsuperscript{158} Ibid.


\textsuperscript{160} Hunter Vs Mann (1974) QB 767 at 772, (1974)2 All ER 414 at 417 per Boreham J.

person’s right to confidentiality occurs only when the person or institution to whom the information was disclosed in confidence fails to protect the information or deliberately reveals it to third person without the consent of the first-party. On the other hand, a person who without authorisation collects information violates rights of privacy rather than right of confidentiality. Only the person or institution who receives information in confidential relationship can be charged with violating rights of confidentiality.

In the medical context, confidentiality is present when the patient discloses information to the health professional through the words or an examination, by virtue of profession, professional pledges not to divulge that information to any third party without the confider’s permission. The mutual trust and confidence protects the information. If a patient authorises release of the information to others, then no violation of rights of confidentiality occurs, although disclosure of confidentiality and privacy may occur. Thus, confidentiality imposes an obligation on the doctor not to disclose except in defined circumstances, information regarding his patient to a third party, whether third party is a relative or stranger.

3.4.2. Origin and Development of the Right to Confidentiality:

The rule of confidentiality appears as if it were a self-sustaining proposition. Indeed, while there is no doubt about the ethical origin, its legal origin is somewhat difficult to state with any degree of certainty.

Rule confidentiality has been recognised in Codes of Medical Ethics. They can be found in most ancient Greece literature formulated by Hippocratic Oath some 2400 years ago and continue in the World Medical Association’s Declaration of Geneva, which asserts an obligation of “absolute secrecy”. The World Medical Association’s International Code of Medical Ethics which states obligation of the doctor to preserve “absolute secrecy” and General Medical Council and British

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162 Supra note 118 p 306.
163 Hippocratic Oath 460 BC: whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart there form, which ought not to be noised abroad, I will keep silence thereon counting such things to be as sacred secrets.
164 Declaration of Geneva as Amended at Sydney, 1968: “I will respect the secrets which are confided in me, even after the patient has died”.
Medical Association guidelines state the confidentiality of information regarding patient\textsuperscript{165}.

The ethical rules apply to all branches of health care providers including nurses, physiotherapists, etc. If a disclosure is made in unauthorised circumstances, then disciplinary action may follow provided a complaint is lodged. The ‘punishment’ will be varying depending upon the code of the particular branch of the profession involved.

Some commentators ridicule ethical rules or obligations as ritualistic formulas or convenient fictions, professionals publicly acknowledge obligations but widely ignore and violate the same in practice. Mark Sieger has argued that “confidentiality in medicine” is a “decrepit concept”, because what both physicians and patients have understood as medical confidentiality no longer exists. Rather, it is “compromised systematically in the course of routine medical care”\textsuperscript{166}. Health professionals themselves reveal the medical records of the patient\textsuperscript{167}. Only patients expect more rigorous standard of confidentiality, whereas, professionals discuss patients’ history with medical students, house-staff, spouses and at parties\textsuperscript{168}.

In India, right of confidentiality has been recognised as deriving from the constitutional right to privacy. The Supreme Court of India has re-affirmed that “doctors are morally and ethically bound to maintain confidentiality. In such a situation, public disclosure of even true private facts may amount to an invasion of the right to privacy which sometimes lead to the clash of one person’s “right to be let alone” with another person’s right to be informed\textsuperscript{169}.

\textsuperscript{165} GMC’ booklet on Good Medical Practice, para 16 says: “Patients have a right to expect that you will not pass on any personal information which you learn in the course of your professional duties, unless they agree. If, in exceptional circumstances you feel you should pass on information without a patient’s consent, or against a patient’s wishes, you should read our booklet ‘confidentiality’ and be prepared to justify your decision.”


\textsuperscript{167} Superior of Court of New Jersey, Law Division, Merceener County, Docket No.1 L. 88-2550 (April 25, 1991)


3.4.3. Legal Recognition of Confidence:

The issue concerning the rule of confidentiality would be, what is the basis for the rule? The rule being ethical code, does it possess legal status? As there is no statutory provision against unauthorised disclosure, is it contractual, tortious, equitable, fiduciary or sue generis? As regards a private patient, the answer is very obvious: the right of confidentiality lies in contract because there is contractual relationship between the patient and the doctor/hospital or the health staff, and the contract will either contain an express terms of confidentiality or the court will ‘read in’ an implied term to that effect in appropriate cases.\(^{170}\)

But the question is regarding the patient who has no contract with the hospital or its staff where the service renders free of charge. As there is no specific tort of breach of confidence, (as there exist tort of negligence), does the obligation of confidence exist in the doctor’s overall duty of care to the patient? It cannot because negligence implies certain degree of inadvertence whereas in the case of an unauthorised disclosure, the actions of the person disclosing are generally deliberate. Nonetheless, in Furniss Vs Fitchett\(^ {171}\), the court held that unauthorised disclosure was actionable negligence in tort, on the ground that it was reasonably foreseeable that the disclosure would cause physical harm to the patient.

Another issue concerning confidentiality would be whether medical confidentiality can be regarded as an independent duty that is not as a part of the doctor’s overall duty of care? It can be argued that instead of one indivisible duty owed to the patient, there should be separate duty owed. However, the House of Lords has held that the doctor’s duty to his patient was legally indivisible\(^ {172}\). Although this duty stems from the ethical code, it is also a legal duty enforceable at law\(^ {173}\). In Morris Vs Consolidation Coal Company, doctor supports the petitioner who claims benefit for a work-related disability from a workers fund. Sometime later, a representative of the company shows the doctor videos of the petitioner digging at a time when he had alleged that he was too injured to work. As a result, the doctor

\(^{170}\) Supra n 156 p 2.
\(^{171}\) (1958) NZLR 396.
\(^{172}\) Sidaway Vs Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital (1985) AC 871.
refuses to certify that the petitioner was unfit for work. The petitioner sued the defendant-doctor for breach of medical confidence. The US court laid down the following principles relating the confidence:

a) The doctor-patient relationship is a fiduciary one.

b) This relationship of trust prohibits communication between the employer and the physician treating the petitioner, notwithstanding the need to investigate fraud.

c) The interest in resolving claims expeditiously demands a communication between the employer and treating physician. This will be legitimate provided legislation authorises release of the records.

d) A cause of action for the breach of confidentiality will lie against a third party who induces a doctor to breach this fiduciary duty if

i) The third party knew or reasonably should have known of the doctor-patient relationship;

ii) The third party intended to induce a wrongful disclosure, or reasonably should have anticipated that actions would have that effect.

iii) The third party did not reasonably believe that the doctor could disclose the information without violating the duty of confidence.

iv) The information was actually disclosed to the third party174.

In event that the plaintiff is harmed physically by the unwarranted disclosure of personal medical information he could bring the medical negligence action.

3.3.5. Confidentiality in India:

In India leading authority concerning the issue of medical confidentiality is *Tokugha Yepthomi Vs Hospital Enterprise Ltd*175. In this case a blood sample obtained from appellant employed under the Nagaland State Health Services found the blood group was HIV(+) . The judgment is silent on the question whether the appellant doctor consented to the HIV test. In the meantime, the appellant’s marriage was called off on the ground that the appellant was found to be HIV (+). As a consequence of this, he contended that he was entitled for damages for the breach of

175 (1998 (6) SCALE 230.
the information which was required to be secret under the medical ethics which obligated the respondent to maintain confidentiality and his “right to privacy” had been infringed by the respondent by disclosing that he was HIV (+).

The court opined that “it is true that in the doctor-patient relationship, the most important aspect is the doctor’s duty of maintaining secrecy. A doctor cannot disclose to a person any information regarding his patient which he has gathered in the course of treatment nor can the doctor disclose to anyone else the mode of treatment or the advice given by him to the patient”. However the court in its conclusion held that ethical professional “rule of confidentiality” was not absolute. The disclosure is permissible “where there is an immediate or future harm to others”. Since proposed marriage carried with it the health risk to identifiable person who had to be protected from being infected with the communicable disease from the appellant, his right to confidentiality, was not enforceable. This decision of the Supreme Court, however, failed to frame a comprehensive code addressing issues such as disclosure by whom, to whom, under what circumstances and subject to what conditions. The ruling seems to have abrogated all rights of confidentiality.

3.3.6. Relaxation of the Rule:

All the classic codes of practice imply that the rule against disclosure is not an absolute rule. Thus, the Hippocratic Oath which state “all that may come to my knowledge….which ought not to be spread abroad, I will keep secret” clearly indicates that there are some things which may be published. The Declaration of Geneva that provides “I will respect the secrets which are confided in me”, the word ‘respect’ is open to interpretation. The GMC, while emphasising ‘professional secrecy’ lists a number of specific exceptions to the rule which provide a sound basis for disclosure.

3.3.6.1. Consent to Publish: Under both the legal rules and the ethical guidelines, there are certain well-defined circumstances, wherein a disclosure can be made by the doctor with the consent of the patient. The patient voluntary consent is necessary. The doctor being mere the temporary custodian of the confidence, cannot come in the way of patient who wishes to divulge his personal data. If the doctor obtains his patient consent to communicate any information, it will not be an exception to the rule
of confidence, rather, it is not confidential at all. Any adult patient and sound mind can give consent for disclosure and the doctor will be bound to acquiesce to those wishes. No court can support the view of the doctor that disclosure would not have been in the patient’s best interest. The doctrine of traditional paternalism has no place play. What is important is, the consenting patient must fully understand both the nature and the consequence of the disclosure, eg. What is to be revealed and who is the intended recipient etc., and also consent has to be freely and willingly given.

Law does not require that consent must be expressed in writing or by word of mouth, it may be inferred from the conduct of the parties or facts and situations of the transaction. Where there is explicit request to release of information, it elides the obligation to secrecy. However, the difficult situation is when the patient has neither consented to nor dissented from disclosure. This situation should be viewed with very cautiously. Because in the absence of express and detailed consent as to what may be disclosed and to whom, there is difficult in identifying the level and breadth of information which it is legitimate to disclose. How many patients know whether the person standing with the doctor at the hospital is fellow doctor, a social worker or just an interested spectator? Would they have consented to their presence if they had been informed? The doctor may be responsible, if there is breach of confidence. But this is the situation where the young doctors and staff are all present at the time of disclosure of confidence to the doctor. It not only renders impossible to give true autonomous consent, but also effectively breaks the confidential doctor-patient relationship. But the GMC recognises this in permitting the sharing of information with other professionals who assume responsibility for clinical management of the patient.

3.3.6.2. Confidentiality and the Legally Incompetent: Consent as matter of ethics as well as law, should be voluntary. However, the point is, is it possible to obtain

177 Supra n 156 p 15.
179 Ibid.
voluntary consent of a patient who is in the vulnerable position of lying in a hospital bed? Is it safer and ethically appropriate in seeking the patient’s consent? Of course, under this situation, it can be inferred that the patient consents the doctor, but one must quary whether the consent is truly voluntary.

Another issue concerning the ability to control the dissemination of information is, can a patient who is not attained the majority under the relevant law consent to disclosure? This question draws the attention of the court in a classical case of *Gillick Vs West Norfolk and Wisbech Area Health Authority*. It is a case of conflict of interest of the parent and the child. While the parent’s natural desire to know what is happening to their child, the child wants to keep information secrets. Law regards a person below the certain age as incompetent to make decisions about medical treatment. This view is what is known as “status approach”. Alternative view which is accepted within the medical law is the “capacity approach” which provides that a child is competent to make decisions on treatment independently of the wishes of the parents. This is subject to the condition that the child is capable of understanding the contents and the implications of the choices and the doctor also sees the welfare of the child is paramount importance. The Court in its historical judgement held, that a mature minor is competent to consent to medical treatment without parental permission and the doctor in this connection has a duty to promote the best interest of the child. However, the court does not fix the particular age at which a child is able to understand the content of the information. It also raise the question whether parents should be kept away in deciding the welfare of the child, what is the role of the parents in relation to the best interest of the child. The concern of the parents is considered by the court in *Re W(a minor) Medical Treatment*, where it was said that although a mature minor can consent to medical treatment, he has no absolute right to refuse where his parent/guardian has consented to the treatment. The two cases appear to take paternalism to even greater heights, and may lead to under age sexual relation, contraception and abortion.

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181 (1986) AC 112; (1985)3 All ER 402.  
183 Ibid.  
184 (1992) 4 All ER 627.
3.3.6.3. **The patient’s Interest**: The break of confidentiality is justifiable when a doctor considers that it is necessary in the best interest of the patient or it is undesirable on medical grounds to seek the patient’s consent. However, so far no case has appeared before the court involving the issue of the disclosure in the patient’s interest. Therefore, what circumstances falls within this rule are unclear? It is stated that in a case where the doctor has genuine reason to believe that the patient is a victim of neglect or physical or sexual abuse or illness or an unrelated third party, the doctor may disclose the information to a third party or relative. But it is the doctor’s duty to make every reasonable effort to persuade the patient to allow the information to be given and to make clear to the third party that the information is given in confidence. Again paternalism dominates in maintaining a patient’s medical confidentiality.

3.3.6.4. **The Clinical interest**: There is no bar on the part of the health carer from disclosing confidential information to any other persons who are responsible for the clinical treatment of the patient. The disclosure can be made to nurses, radiologists, physiotherapists, etc, and it remains the duty of the health carer to make best possible efforts to secure the consent of the patient. But the treating doctor owes his obligation to state that information was of a confidential nature. However, it is not certain to what extent people outside the medical treatment can receive such information. For example, can a social worker be informed the specific details of a patient’s illness? Under this case, the doctor has to act in accordance with good clinical management practice.

3.3.6.5. **Public Interest**: There is also a public interest in maintaining confidence. Where there is a conflict between a private interest and a public interest, law prefers the latter over the former. Such a position, no doubt leads to erosion of the strict duty of the professional to protect confidential information and there is possibility of competition between the two interests: protection of the public interest and protection of the medical secret.

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185 Supra note 175 p. 244.
186 GMC “Confidentiality” Booklet para 2.
187 GMC “Confidentiality” Booklet paras 3-8.
A doctor in order to take a defence to an action for breach of confidence, it should be shown that the disclosure of information was in the public interest rather than it was interesting to the public attention. In X Vs Y\textsuperscript{188}, the health authority successfully obtained an injection prohibiting a tabloid newspaper from publishing the names of two doctors who were being treated for AIDS. The court held that while the information was interesting to the public, public interest maintained that their identities should not be revealed as this would potentially discourage fellow AIDS sufferers from the seeking treatments.

The issue of public interest appeared as the main focus in W Vs Egdell\textsuperscript{189}, W was detained in a hospital on the ground of public safety after he had killed five people and wounded two others. After sometime, W made an application for review before a Tribunal with a view to discharge. Dr. Egdell had been asked by W’s solicitors to prepare a report in support of W’s application. His report was unfavourable to W as he considered that W would be danger to the public if he was ever released. This report was also sent to the Secretary of State who opposed the application. W sued Dr. Egdell alleging a breach of the duty of confidence. The issue before the court was, whether Dr. Egdell was under a duty of confidence? W contended that maintaining confidence itself would be in the public interest of safety, and whatever communicated with the doctor should not be publicised. On the other hand, Dr. Egdell argued that disclosure was in the public interest as W might be danger to the public in future. Assessing the doctor conduct in terms of the interest of public safety, the court laid down the following guidelines:

a) Disclosure should be limited to those which are regarded as vital information.

There would be no justification, in disclosing information for financial profit:

b) The risk if the material is not disclosed, must be real rather than fanciful; and

c) This real threat needs to be of physical as opposed to some other form of harm.

This case was followed in R Vs Crozier\textsuperscript{190}, where a psychiatrist acting for the accused handed his report to the prosecutor for the state. It was justified on the ground that the accused was a danger to the public than in the confidence being maintained. What reveals from the court is that there must be a risk of harm to the

\begin{footnotesize}
\begin{itemize}
\item [\textsuperscript{188}] (1988) 2 All ER 648.
\item [\textsuperscript{189}] (1990)1 All ER 835.
\item [\textsuperscript{190}] (1991) Crm LR 138.
\end{itemize}
\end{footnotesize}
public and it must be necessary for the information to be disclosed. However, from viewpoint of patient the ruling represents serious inroads into the doctor-patient relationship and the trust a patient can have in the doctor keeping the confidence. The court doesn’t require to balance the risk of harm against the public interest and maintain the doctor-patient confidence. Because, the doctor owes to his patient a ‘primary duty’ to protect him rather than concern with the interest of third party who is likely to be affected by the act of his patient. Is there any legal duty on the part of the doctor to prevent harm to the third party? Absolutely, there is no duty to rescue. By contrast, imposing duty on the part of the doctor towards third parties lands the doctor in dilemma, how the third party proves that the doctor’s knowledge of risk responsible for the injury and how would it be just and reasonable to hold the doctor liable for the wrong committed by his patient? Therefore, the chances of third party success are thin.

3.3.6.6. For the purpose of Medical Research etc. A moot point concerning medical confidentiality is whether the disclosure of information for the purposes of teaching and medical research constitutes breach of confidentiality. It is stated that information may be disclosed for the purpose of teaching or medical research which has been approved by a recognised ethical committee. There is no breach of confidence where the information is used does not reveal identity of an individual, for instance, where a doctor writes an article about a patient’s condition without identifying the specific individual. But, information which reveals the identity of an individual, the researcher must obtain the patient’s consent. It should be noted that whether or not identity is disclosed, still there has been a breach of confidence and action sustainable where any damage is caused by the breach. By contrast, in England the Health and Social Care Act 2001 allows the Secretary of State to make provisions

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191 Supra note 179 p. 36.
193 GMC’s “Confidentiality” Booklet paras 15-17 discuss confidentiality and research: Patients must be informed of their rights to withhold consent to disclosure. Where consent cannot be obtained, then the research ethics committee must decide whether the public interest in the research outweigh the public interest in the preservation of the patient’s confidence. The patient’s consent must be obtained for use of confidential information in teaching unless such information is anonymous.
194 Ibid 156.
requiring or regulating the processing of patient medical data in their own medical interests or in the public interest, including research interests.\textsuperscript{195}

The Regulations made under this Act allow confidential patient information to be processed with a view to diagnosing communicable diseases, preventing the spread of such diseases and risks, monitoring and managing outbreaks of communicable disease, and giving information to persons about the diagnosis of communicable disease and risks of acquiring such disease etc. The wide-sweeping discretion of the Secretary of the state has been criticised as unduly preferential of the amorphous and ill-defined ‘public interest’ compared to individuals private interest in confidentiality of their medical data.\textsuperscript{196}

Inspite of the criticism, there is evidence wherein the Department of Health has tried to safeguard the confidentiality of data relating to patients. In \textit{R Vs Department of Health, exparte Source Informatics Ltd}\textsuperscript{197}, Court examines the legality of the rule which requires that pharmacists to provide details of general practitioners prescribing habits and all data concerning patients to a firm that intends to sell them to pharmaceutical companies for the purpose of marketing their products. Accordingly, pharmacists were asked to supply the required data. The Department of Health objected the rule as violates patients confidentiality and there no provision for obtaining patient consent. The court however ruled that there was no breach of confidentiality.\textsuperscript{198} In the court’s view, patient privacy was not under threat because there was no realistic possibility of revealing the identity of patients. The decision challenges the law of confidence, was it shifts the basis of duty of confidence from the public interest to the question of fairness of use. In the light of the decision in \textit{Source Informatics}, the position now represents that there is no breach of confidence where there is fairness in the use of information.\textsuperscript{199} This goes against the well-established principle that the confidentiality has rooted in the public interest and the information

\textsuperscript{195} Regulations made under section 60 of the Act, state that “ Anything done by a person that is necessary for the purpose of processing patient information in accordance with these Regulations shall be taken to be lawfully done despite any obligation of confidence owed by that person in respect of it, and also see Health Service (Control of Patient Information) Regulations 2002, SI 2002/1438, Reg. 4.

\textsuperscript{196} Beyleveld ‘ How Not to Regulate in the Public Interest’ (2002)2 Genetics L Montr 5

\textsuperscript{197} (2000)1 All ER 786, (2002)52 BMLR 65.

\textsuperscript{198} Ibid p. 797.

\textsuperscript{199} Supra note 175 p. 259.
provided in confidence should not be used for any purpose except in the public interest. The decision in *Source Informatics* does not indicate upon whom onus of proof lies, is it on the confider who challenges that his information being used unfairly? The impact of the decision in fact reduces the legal interest of the patient in protecting confidentiality, and disregards some of issues like the consent of the patient, importance of maintaining respect for confidence.

3.3.6.7. Court Orders and Statutory Duties: Another situation where the doctor will have to breach the confidentiality would be when he is ordered to do so by the courts or legislation. The court may, in the course of legal proceedings order a doctor who is a witness to disclose information about his patient. The doctor in the witness box has absolute privilege and is immune from the action for breach of confidence. The order of the court cannot be ignored; the practitioner has no choice but to oblige. Refusal to comply with exposes the doctor into a charge of contempt of court. The court will take precedence even when there is a statutory obligation of secrecy.

The immunity of the doctor in court extends to pre-trial conferences/proceedings, again the doctor has no choice, his report will have to be made public. In *Hay Vs University of Alberta Hospital*, the plaintiff sued the health authority for damages arguing that his medical record should not have been disclosed without his consent. His claim was rejected on the ground that production of the medical record required in the interest of justice.

Sometimes a doctor will be under a legal duty to disclose information as it is require by the legislation. In such a case consent of the patient would not be necessary. For instance, a doctor owes a duty to inform the health authority where he come across the patient infected with HIV or any other notified disease.

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200 Watson Vs M’Ewan (1905) AC 480 at 486 (HL).
201 Garner Vs Garner (1920) 36 TLR 196.
202 Naylor Vs Preston Area Health Authority (1987) WLR 958 at 967.
204 Example, the doctor’s duty to disclose infectious disease under the Public Health (Infectious Diseases) Regulations 1988, and the Abortion Regulations 1992 and National Health Service Trust (Veneral Diseases) Regulations 1974.
3.3.6.8. Other Social Groups: There are some special groups which can be considered as creating certain dilemmas in connection with medical confidentiality such as accused persons, prisoners and members of the armed forces. Accused persons are presumed to be innocent in law, until the guilt is proved. They have the same rights as any member of the public. The accused should be informed that his examination report will be revealed to the third party and the examination will not be done, if the consent is refused. Subjecting the accused to the medical examination against his will and disclosing the same report to the third parties complicates the health care-recipient relationship. Similar problems arise in respect of the medical officers and member of the armed forces.

Finally, another situation in which the health carer is compelled to disclose confidential information would be when the health carer is employed by companies to act as medical advisor. In *kapfunde Vs Abbey National Plc and Daniel*205, a doctor is employed to conduct regular examinations on staff and report to the employer if the health information affects the employer business. A patient sued the doctor for damages alleging that disclosure of information constitutes breach of confidentiality. It was held that before the examination the patient has been explicitly informed that results of the examination will be communicated to the employer, therefore, the patient right of confidentiality is not violated. Here, the court has considered the fact that the doctor owed a duty as an employee to his employer, rather than the person concern suffered economic loss and loss of employment in case of error in the examination.

Apart from the aforesaid exceptional circumstances any information revealed by the patient is subject to the strict obligation of the secrecy. Even if the case falls within the scope of the relaxation rule, a health carer is bound to ensure that there is no excessive disclosure of the information. Only a portion of the information which is so essential based upon the “need to know” doctrine should be disclosed. The obligation to keep information confidential extends even after the patient has died. Unauthorised or excessive disclosure can be brought within the case of “medical

negligence” as the breach of confidentiality constitutes breach of duty of the health professionals.

3.3.7. Patient Access to Information:

The issue of access to information poses two questions; does the patient have unfettered access to personal medication information? And at law, who owns and controls intimate information? Before going to quest for answer, let us look at the issue from human rights angle. WHO document\textsuperscript{206} with unequivocal language states about rights of information access as follows:

\begin{itemize}
  \item[a)] All information must be kept confidential, even after death;
  \item[b)] Information can only be disclosed if the patient give explicit consent or if the law specifically provides;
  \item[c)] All identifiable data must protected;
  \item[d)] Patients have the right of access to their medical files and so forth which pertain to diagnosis, treatment and care;
  \item[e)] Patients have right to require the correction, completion, deletion, clarification or updating of personal and medical concerning them which are inaccurate, incomplete, ambiguous, outdated or which are not relevant for the purpose of diagnosis, treatment and care;
  \item[f)] Information may only be withheld from patients exceptionally where there is good reason to believe that the information would without any expectation of obvious positive effects cause them serious harm.
\end{itemize}

However, neither the WHO document nor medical law makes an attempt to address a basic question, who owns the information. In the past, a patient had no access to medical data, if any patient wanted from the doctor/institution; the recourse for it was legal action. Now, it is the right of the patient to see his own medical data\textsuperscript{207}. In Europe the Data Protection 1984, which had now been replaced by the Data Protection Act 1998 enacted in response to the EU Data Protection Directives1995 covers not only computerised data but also data which is manually stored in filing systems. A patient has to be informed and supplied copy of the data and the data may be refused on the ground that the disclosure causes harm to the interest of the patient. \textit{In R Vs Mid Glamorgan exparte Martin}\textsuperscript{208}, a patient who suffers from severe psychiatric problems is given psychotherapy with the support of a social worker. During the course of his treatment, the patient develops emotional attachment with the social worker. Therefore as part of clinical management of the

\textsuperscript{206} Supra note 82.
\textsuperscript{207} Supra note 175
case, that social worker is removed from the participation. Because of that, the patient demands relevant notes particularly information relating to the removal of that social worker. It was held that the defendant has right to refuse access under the statute, the patient cannot seek the data which causes harm to him. The decision shows that the ownership vests in the treating institution, the patient right to information is not absolute.

However, breach of confidentiality falls within the ambit of actions for medical negligence, therefore, at this juncture, it is very much important to focus on the nature and scope of medical negligence.

### 3.4. MEDICAL NEGLIGENCE:

The term ‘medical negligence’ does not exist in a vacuum as some sort of clearly defined legal concept. It is always related to a particular fact or situation. It is for this reason that judicial decision in this area seldom creates any precedent that will necessarily dictate conclusion in a subsequent case. Medical negligence is called “medical malpractice” or “medical malpraxis”, but this is not quite accurate since it includes all form of irregular medical practice and makes no difference between professional negligence and professional misconduct. There is no clear explanation in law as to the nature of medical negligence; this ambiguity leads to state that it is not only a tort but also a crime, although law of medical negligence is generated out of civil action. Gross negligence or involuntary manslaughter constitutes criminal negligence. A simple carelessness or a mere failure of the practitioner to take care amounts to tort. Gross criminal negligence occurs where the practitioner or health carer disregards for the life or safety of the patient and such act attracts punishment as a crime.

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209 Ibid.
211 Sir William Backstone, is the first person to use the word ‘medical malpractice or praxis in 1768, Blackstone, 3 BI Comm. 122.
212 Cox HWC., Medical Jurisprudence and Toxicology, Dr. Dikshit C. Lexis Nexis: Butterworths, 7th ed. 2000, p 77
214 R Vs Bateman (1925)19 Cr. App. R.8.
In terms of tort, negligence is said to be ‘the breach of a duty caused by omission to do something which reasonable man would, or doing something a prudent and reasonable man would not do’\textsuperscript{215}. This makes no difference between medical negligence and any other type of negligence. Medical and non-medical negligence is one and the same. Yet, this definition has been followed by the courts of commonwealth nations including India\textsuperscript{216}.

### 3.4.1. Definitions of:

As the term itself suggests, medical negligence relates to the medical profession and is the result of some irregular conduct on the part of any member of the profession or related services in discharge of professional duties\textsuperscript{217}. As such medical negligence can be termed as a kind of professional negligence which focuses on the ‘improper conduct’ of the professional. If this meaning is accepted as precise definition of the concept of negligence, then difficulty would be posed to distinguish between professional/medical negligence and improper/irregular conduct. Whereas the former relates to the duties of a doctor towards his patient, there is consequential damage to the patient and charges are brought before the court of law, the latter relates to the violation of codes and ethics of medical practice, damage need not be there and charges are brought before the medical council, for instance criminal abortion, adultery, advertisement etc.,

In terms of the concept of ‘duty of care’, professional negligence in case of doctors has been described as “lack of reasonable care and skill…whereby the health or life of a patient is endangered”\textsuperscript{218}. This definition casts a moral obligation on the medical man to assist a patient with his expertisation. Every doctor will be bound to treat ill person who visits him with the request of medical assistance. The question arises as to the exact point of time when the duty of the medical man initiates, and when the doctor owes a duty of care to the particular ill person. It can be said the obligation of the medical man gets set from the point of time when he accepts rather than initiates the treatment of a patient. From then on, he is bound to exercise due care and caution, utilising his professional knowledge and skill for the welfare of the

\textsuperscript{215} Supra note 2.
\textsuperscript{216} Paramananda Katara Vs Union of India 1989 ACJ 1000 (SC).
\textsuperscript{217} Virendra Singh Vs National Institute of Medical Sciences and Others, III(2005) CPJ 757 at 761
\textsuperscript{218} Guptha Jaiprakash, “Ethics and Law Controlling Medical Practitioners, “ AIR 2002 p 305
patient\textsuperscript{219}. Still, the question remains, what does constitute reasonable care and skill, what are the standards to be adopted in determining lack of reasonable, thus, the definition has failed to lay down parameters for the interpreting the term ‘reasonable’ and phraseology ‘reasonable skill’. All these ultimately create confusion not only for the patient but also for the medical man.

The question of medical negligence was considered by the court in the context of treatment of a patient, as it was observed as under\textsuperscript{220}:

“Negligence has many manifestations- it may be active negligence, collateral negligence, comparative negligence, concurrent negligence, continued negligence, criminal negligence, gross negligence, hazardous negligence, active and passive negligence, wilful or reckless negligence or negligence per se which is defined in Black Law dictionary as under:

‘Negligence per se,- conduct, whether of action or omission which may be declared and treated as negligence without any argument on proof as to the particular surrounding circumstances, because it is in violation of statute or municipal ordinance or because it is so palpably opposed to the dictates or common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule the violation of a public duty enjoined by law for the protection of person or property, so constitutes’”\textsuperscript{221}.

Negligence is the breach of duty of the doctor imposed by law keeping in view the protection of the patient’s care. It may be accepted in part, since it focuses on the ‘accountability’ of the doctor in the discharge of duties. This dictionary meaning helps in the literal construction of the language, but it is not panacea to resolve the complexities of the doctor-patient relationship.

\textbf{HWC Cox} attempts to define medical negligence as “the breach of the duty owed by a doctor to his patient to exercise reasonable care and skill, which results in some physical, mental or financial disability”\textsuperscript{222}. This definition appears to be replica of \textit{Winfield’s} definition of negligence in terms of tort or civil wrong. As pointed out,
medical negligence is no different in law from any other type of negligence. It is very rarely action for negligence between the doctor and the patient may be initiated in criminal court. Where the State prosecutes the doctor for a severe degree of reckless and dangerous behaviour amounts to ‘criminal negligence’\textsuperscript{223}. In view of this, Winfield and Cox, medical negligence is form of negligence in which a patient brings an action for damages in civil court against his medical practitioner, who owed him a duty of care in tort, if he had suffered injury in consequence of negligence or unskilled treatment\textsuperscript{224}. This definition involves two constituents:

a) Breach of duty to exercise reasonable care; and

b) Consequential damage.

Accordingly, so far as persons engaged in the medical profession are concerned, every person who enters into the profession, undertakes that he is possessed of a reasonable degree of care and skill to give medical advice and treatment, such a person when is consulted by a patient owes him certain duties, namely,

a) A duty of care in deciding whether to undertake the case;

b) A duty of care in deciding what treatment to give; and

c) A duty of care in the administration of that treatment,

The breach of any of those duties is what is known as “negligence” for which the patient gets a right of action for damages or on the basis of which the patient may recover damages from his doctor\textsuperscript{225}. The definition is based upon the existence of duty; as such negligence and duty are correlated to each other. The question of negligence cannot be viewed in isolation of the duty of care.

A more appropriate and accepted definition can be found in a famous Bolam’s case\textsuperscript{226} wherein Mc Nair J defines in the case of a medical man, negligence means “failure to act in accordance with medical standards in vogue which are being practiced by an ordinarily and reasonably competent man practicing the same art”.

\textsuperscript{223} Ibid.
\textsuperscript{224} Franklin C.A, Modi’s Jurisprudence and Toxicology 21st (ed), Tripati Private Limited 1988
\textsuperscript{226} Bolam Vs Friern Hospital Management Committee, (1957)2 All ER 118; (1957)1 WLR 582.
where there are more perfectly proper standards, if the medical man conforms with any one of those standards, then he is not negligent. Justice McNair, seems to have focussed on the test to determine the liability of the medical man, rather than analysing the appropriate definition of the concept of medical negligence. Each word used in the analysis is so vulnerable to different interpretation example words like reasonable and competent doctor, medical standards and so on. The definition ensures protection to the medical man instead of covering the components of the term medical negligence. As such, it does not highlight the issue of basic ingredients except stating that the failure to act according to medical standards. However, the view of McNair cannot be rejected out-rightly as it is necessary to understand what may or may not amount to negligence.

To sum up, medical negligence maybe described as want of reasonable care and skill or wilful negligence on the part of a doctor in respect to acceptance of a patient, history taking, examination, diagnosis, investigation, treatment (medical or surgical) etc., resulting in injury or damage to the patient. For instance prescribing treatment without taking history, without recording the signs and symptoms of disease, without investigation and diagnosis or not carryout necessary tests before starting administration, fail to issue warning regarding side of effects of the drugs or not monitoring the treatment, leaving foreign articles in the operation site, or performing operation on the wrong site of the patient, wrong dosage of injection, use of wrong drug or wrong gas during the course of anaesthetic etc.,

In Varadha S Nair Vs Dr. Remani, a woman approached the hospital to undergo treatment for carcinoma rectum. After the operation, she was absolutely normal but advised chemotherapy for two-and-half-years and follow up for 6 months. She had to undergo regular check up once in six months which consists of colonoscopy and endoscopy. She consulted the defendant for routine check up. On a perusal of the case records, the defendant advised for hysterectomy, even though as

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227 This definition has been approved by the House of Lords in Whitehouse Vs Jrodon, (1981)1 All ER; (1981)1 WLR 246 (HL); Maynard Vs West Midlands Regional Health Authority (198501 All ER 635; (1984)1 634(HL) and Sidaway Vs Bethlem Royal Hospital (1985)1 All ER 643; 1985 AC 871; (1985)2 WLR 480(HL).
229 III (2005) CPJ 36 (NC)
per the report she was normal and no need to undergo surgery and only follow up was necessary. While performing operation, defendant cuts the small intestine accidentally, removes the uterus and the ovary and cuts rectum, further, the defendant performs the operation for the removal of appendix without obtaining consent, although the patient had cough, wheezing, body pain especially in stomach as result of the hysterectomy. The patient was in vegetative state.

Several questions came up for the consideration of the court such as, was there emergent necessity of hysterectomy, was there any emergent operation for removal of appendix where the patient was diagnosed having a ‘Cystic Ovary’, what was the required treatment. On the perusal of evidence of the medical experts, the court found that there was erroneous /negligently cutting of the rectum, there was no necessity of having emergent hysterectomy operation, the required treatment was to remove ovarian cyst, and there was no necessity of operating appendicitis in such a complicated situation. The patient was subjected to total abdominal hysterectomy, repair of rectum, appendicectomy burying stump, repair of small intestines. For no fault of her, these uncalled for operations were performed on the patient. The court in its conclusion held that it is case of ‘medical negligence’ by which the patient is living crippled.

In another case of Sandeep Agarwal Vs Modern Medical Institute230, a medical student who could not have sleep for a week consulted the respondent doctor who treated him for depression. No investigation, no pathological tests were conducted. Medicines prescribed for one week mechanically repeated for another two weeks. After that, the respondent prescribed lithium along with other drugs a well known for its side effects. The doctor did not carryout necessary tests prior to starting administration of lithium. Under the medical textbooks, before starting lithium therapy various texts are required to be done. Thorough medical examination including blood pressure, records of weight of the patient, urine test, thyroid function tests along with ECG are required to be done. Before starting lithium, the doctor is under obligation to explain regarding possible side effects of lithium, like diarrhoea, vomiting, dehydration and stop lithium immediately, because such symptoms will

have disaster effects. However, no such advice is given. The respondent admits in his testimony that some tests are necessary prior to starting lithium like blood test, urine test etc., are necessary but denies that thyroid test is necessary and the need of educate patients about the limitations of medical treatment and the risk involved in surgical and medical treatment.

Whereas, the respondent places reliance on the rulings of Shantaben Muljibahi Patel Vs Beach Candy Hospital and Research Centre\(^\text{231}\) where it was held that the doctor cannot be held negligent, where he has performed his duties to the best of his ability and with due care and caution and Kusum Sharma Vs Batra Hospital and Medical Centre\(^\text{232}\) wherein it has been observed that a doctor is not negligent, if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. The court agreeing with these settled legal position, held that the respondent has failed to take reasonable care during various levels of treatment, firstly, the doctor did not record history of the patient while writing prescription, did no suggest for relevant tests prior to starting lithium therapy and issue advice and warning regarding lithium in writing, did not properly monitor serum lithium level for a long time, although he administered heavy dosage of lithium along with other drugs without taking proper care and caution leading to permanent vegetative state of the patient. The respondent has breached his duty to act as prudent and reasonable competent doctor in the circumstances of the case. The court reiterated the definition of negligence:

> “Negligence is the breach of duty caused by the omission to do something which a reasonable man, guided by those considerations which regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do, the doctor is not negligent, if he demonstrates standards of the ordinary skilled man exercising and professing to have that skill, as held in the Bolam case\(^\text{233}\)”

Thus, medical negligence or malpraxis is doing something that one is not supposed to do, or failing to do something that one is supposed to do, or in other

\(^{231}\) I (2005) CPJ 10 (NC)
\(^{232}\) III (2000) CPJ 18 (NC)
\(^{233}\) Supra note 225.
words, absence of reasonable care and skill on the part of medical practitioner in the
treatment of a patient which causes bodily injury or death of the patient.

3.4.2. Components of: The analysis of the concept of negligence involves the three
essential components which are sine qua non:

A. That the doctor had a ‘duty of care’ towards the patient
B. That the doctor was in breach of that duty, i.e., that is failed in that
duty;
C. That as a result the patient suffered damage

3.4.2.1. The duty of care: Basic structure in the medical context

3.4.2.1.1. The duty Arising:

Issue of whether the health carer owes a duty of care or not will be determined
as an issue of law by the court. Generally, the health carer owes duty of care to his
patient. This ‘duty’ is indivisible duty\(^\text{234}\). In the legal context, the duty of care is not
a problem. But one needs to move on the area where difficult question arises relating
to arising of duty and the proper scope of the duty. These questions are most
effectively articulated by the court in \textit{R Vs Bateman}\(^\text{235}\). In terms of medical
negligence, the term ‘duty of care’ is synonymous to the concept of the ‘undertaking’
towards the patient. The duty of care involves: a) duty to possess special skill and
knowledge; b) duty to use caution in treatment/diagnosis; c) duty to use diligence,
care, knowledge, skill and caution in administering treatment\(^\text{236}\). The legal duty arises
as soon as medical treatment undertaken by the health carer. Some commentators
such as \textit{Charles Lewis} states that duty arises simply out of the physician-patient
relationship irrespective of the time at which treatment begins and the duration at
which the treatment continues\(^\text{237}\). The moment the doctor assumes the responsibility
towards of the patient, establishes the duty of care. However, there is no general duty
on the part of the health carer to provide treatment for all sick persons or injured
people, moreover, the claimant must establish the existence of special relationship
between the claimant and health carer which creates a duty to exercise due care\(^\text{238}\). It

\(^{234}\) Supra note 156.
\(^{235}\) Supra note 213.
\(^{236}\) Ibid.
\(^{237}\) Supra note 209.
is unclear as to factual situation where the undertaking becomes legal one with or without physician-patient relationship and whether the health carer owes a duty to the satisfaction of the patient.

Margaret Blazer indicates that where a patient establishes the physician-patient relationship, the doctor owes him a duty of care\textsuperscript{239}. As such, the duty of care does not arise until a definite undertaking procedure or hospital admission procedure is completed and the patient is allocated a bed. This idea has the advantage of certainty, the freedom of choice of the health carer, and a proximate relationship between the parties but it is unable to take into account of the myriad complexities encountered in the practice of medicine\textsuperscript{240}.

The normal doctor-patient relationship giverise to a duty of care in tort. A doctor who holds himself out as possessing as special skill and knowledge, it he is consulted by or on half of the patient, he owes duty to the patient to use due caution in undertaking the treatment\textsuperscript{241}. In \textit{Pippin Vs Sheppard}\textsuperscript{242}, where the defendant surgeon had been employed to treat, attend to and cure grievous hurts, cuts etc., of the petitioner. As a result of careless treatment, ‘the said wound became inflamed grievously aggravated and made worse’. His life was also endangered and had to undergo further treatment by other surgeon. The issue was whether patient had employed the defendant to treat him, was there clear establishment of physician-patient relationship. The court arrived at the conclusion that the fact of who retained or employed the defendant was immaterial; it was enough that the surgeon had treated the patient. Further, it was also unnecessary for the petitioner-patient to demonstrate that the surgeon owed a duty or he had undertaken to treat the plaintiff skilfully\textsuperscript{243}. This ruling has been criticised by posing some questions, is the doctor’s duty owed only to the patient? Is that duty owed only in respect of strictly medical treatment? Is he liable only for losses coming within the scope of his medical treatment? Is physician-patient relationship not incompatible with the concept of the Good

\textsuperscript{239} Margaret Blazer, Medicine Patients and the Law, 2\textsuperscript{nd} (edi) London: Penguin, 1992, pp. 117-18.
\textsuperscript{240} Davis Michael, Textbook on Medical Law 1\textsuperscript{st} (ed) London: Blackston Press Limited, 1996, p57.
\textsuperscript{241} Supra note 213.
\textsuperscript{242} (1822) II Price 400.
\textsuperscript{243} See Edgar Vs Lamount (1914 (SC) 277, in which the court held that the doctor owed a duty to the patient irrespective of who actually paid the bill.
Samaritan\textsuperscript{244}\? Is there no duty, without a relationship based on the status of the parties? What is the position if doctor simply gives advice based on a person’s medical records\textsuperscript{245}\?

In \textit{Kapfunde Abbey Vs National plc}\textsuperscript{246}, a doctor is employed by the defendant company to act as its independent advisor. As per the norm of the employment, the doctor has to examine and report to the defendant company any sickness of employees affecting the business. The doctor who examined the claimant advised the defendant that she was unsuitable to work due to her sickness. The defendant refused to employ the claimant. Hence, the claimant sued the doctor for negligence in advancing erroneously. The court said that, even if it was foreseeable that the claimant would suffer financial loss if the doctor was careless, there was no direct doctor-patient relationship. The doctor had not assumed a duty of care to the claimant\textsuperscript{247}. In a similar case of \textit{N Vs Agarwal}\textsuperscript{248}, the defendant doctor who examined the petitioner who was suspected rape victim, did not appear before the court and offer testimony as a witness. She argued that the doctor had a duty of care to attend, because of breach of this duty, the trial collapsed and she suffered psychiatric harm. It was held that in carrying out such examination, the doctor not assumed responsibility for the petitioner and as there was no proximity to create a duty of care, the doctor-patient relationship did not arise. The ruling represents neither the duty of care nor special relationship arises where the health-carer is consulted for any purpose other than the ‘medical treatment’. It giverises a question as to the treatment. The word treatment includes diagnosis and suggests the course of action to follow, accordingly, a duty of care will not arise where a person is examined by the health-carer to test drunkenness at a police station or assess for the purpose of insurance cover\textsuperscript{249}.

\textsuperscript{244} Lee, R. “Hospital Admissions-Duty of Care” (1979) 129 NLJ 567.
\textsuperscript{245} Supra 236.
\textsuperscript{247} The court overruled Roy Vs Craydon Health Authority (1997) PIQR P444 CA; (1998) Lloyd’s Rep Med. 44. CA where it had been held that the defendant-doctor owed a duty of care to prosepctive employee as well.
\textsuperscript{248} (1999) as cited at supra 237.
\textsuperscript{249} See also in M Vs Newham London Borough Council (1995)2 AC 633, (HL), where it was held that no duty of care owed without there was sufficient proximity or speical relationship between the physician-claimant.
3.4.2.1.2. The duty owes to whom: Third parties!

In determining the extent of duty of care, a question arises whether the duty of care is owed to a non-patient third party. The cases cited in the foregoing discussion demonstrate that in general, the courts are reluctant to impose duties on the health-carer in respect of the third parties who have suffered harm as a result of his action. If the physician-patient relationship is not established between the physician and injured, there is no duty of care to the physician. The issue of duty to the third party is settled in two American cases of Tarasoff Vs Regents of the University of California and Bradshow Vs Daniel. In Tarasoff’s case, it has been held that the defendant-health carer could not escape liability on the simple defence that the third party was not his patient; there was a positive obligation to use reasonable care to protect the ‘identifiable’ third party from the source of the danger. Similarly, in Bradshaw’s case, the court held that a physician did owe a duty to a non-patient third party in respect of injuries caused by the physician’s negligence in a circumstance where the injury could have been reasonably foreseen. But the English common law is yet to decide the question of recognising such a duty of affirmative action on the health-carer. The duty of a medical practitioner towards a third party can be established under the proximity relationship, just and equitable rule and reasonable foresight doctrine. There is no why the English courts do not wish to impose additional duties on the health-carer. However, in non-medical cases, a duty to a third party has been upheld in Home Office Vs Dorset Yacht Company Limited where liability was imposed for the negligent supervision of trainees by Home Office employees. In Donoghue Vs Stevenson, House of Lords pointed out that manufacturer of any goods owes a duty of care to the ultimate consumer.

Recently, there was an exotic attempt to develop the duty of care owed to third parties in the context of physical violence, nervous shock and preoperative medical

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250 Powell Vs Boldaz, 1998 Lloyd’s Rep Med 116, CA the court struck down the claim of third party who suffered psychiatric injury for the death of her son by reason of negligence of the defendant-physician.
253 Supra note 175.
254 Supra 158.
256 Supra note 21.
257 Taylor Vs Somersault Health Authority (1993) 4 Med. LR 34.
advice\textsuperscript{258}. In a leading case of \textit{W Vs Egdell}\textsuperscript{259}, the doctor sends to the State a confidential report stating that his patient’s behaviour will be dangerous to the life public if he enlarges on bail. The court finds that the doctor owes a duty of care where there is specific physical violence to the third parties. In \textit{Thake Vs Maurice}\textsuperscript{260}, the plaintiff who underwent a vasectomy had not been warned of the risk that vasectomy might fail to sterilise sometimes. The plaintiff’s wife became pregnant. The defendant contended that the action was not maintainable due to lack proximate relationship between himself and the plaintiff wife. The court observed that failure to warn the risk of failure was a breach of surgeon’s duty of care that he owed to both the husband and his wife on the ground that the third party was identifiable and injury was reasonably foreseeable. In \textit{G Vs North Tees Health Authority}\textsuperscript{261}, a child was admitted to the hospital for a skin problem. The report disclosed the presence of active male sperm, indicating sexual abuse. The child was subjected to various internal examination and series of interview by police-officers and social workers. As a consequence of the incident, the mother was extremely upset and depressed. Her family reacted badly and she felt suicidal. It was later on discovered that mistake had been done by the staff in examining pathological report. The issue was whether the defendant owed duty of care to the plaintiff who was not a patient and undertaken treatment. The court held that the plaintiff was one who was directly and proximately affected by the act of the defendant, as such, the defendant owed duty of care towards the plaintiff.

\textbf{3.4.2.1. 3. Legal duty and Embryo}\textsuperscript{262}:

One of the amazing questions concerning the duty of care is whether the health carer owes a duty of care towards an embryo. It is crystal clear that a duty is owed to the pregnant mother since she is being treated. But can it be said that a duty is also owed to the embryo while it is in the uterus\textsuperscript{263}. These questions came up for

\textsuperscript{258} Goodwill Vs British Pregnancy Advisory Service (1996)2 All ER 161.
\textsuperscript{259} (1990)1 All ER 835.
\textsuperscript{260} (1986) QB 644.
\textsuperscript{261} (1989) FCR 53.
\textsuperscript{262} The Congenital Disabilities (Civil Liability) Act 1976 extends duty of care owed by a medical practitioner to the unborn child.
\textsuperscript{263} Ibid.
the consideration of the court in *Burton Vs Islington Health Authority*\(^{264}\); and *De Martell Vs Merton and Sutton Health Authority*\(^{265}\). In the former case the negligence was said to have happened during a dilatation and curettage operation and in latter case a child was born with brain damage following a failure of forceps delivery and a subsequent delivery by a caesarean section. The court in its landmark judgment addressed two issues. Firstly, a duty is owed to an embryo but it is contingent one which will only be fulfilled when the child is born alive; and secondly, because of the contingent nature of the duty, the mother cannot bring a litigation for and on behalf of her unborn baby\(^ {266}\).

This viewpoint implicates that the doctor owes to the parents a duty of care which is subsequently broken and as a result of breach, the child is to born with disabilities; and the child is to born alive. If the child is dead in the mother's womb itself will not giverise a cause of action for medical negligence. It raises a question, whether the doctor owes a duty to avoid pre-conception negligence. Under English common law, there is no duty as such. In Australian case of *X and Y Vs Pal and others*\(^ {267}\), the court voiced a new approach thus, in principle it should be accepted that a person may be subjected to a duty of care to a child who was neither born nor conceived at the time of his careless act or omission, he may be found liable in damages to that child. This duty in law arises depending upon whether there is a relevant relationship between the careless persons and the person to whom the child is born\(^ {268}\).

### 3.4.2.1.4. The duty owes by whom

It is necessary to explore the question who owes duty of care? If it is answered thus, the medical practitioner owes a duty of care to his patient or any third person who is likely to be affected by his negligence, again some questions come up: who is a medical practitioner? Can a medical practitioner practice any branch of medicine? What is the importance of the concept of duty in practice of medicine? The issue of medical practitioner and required qualifications of the practitioner came

\(^{264}\) (1991)2 Med.LR 133.


\(^{266}\) Mc Kay Vs Essex Health Authority (1982) QB 1166 CA, the duty owed to the unborn child was conceded.


\(^{268}\) Ibid at p.207.
up in Poonam Varma Vs Ashwin Patel\(^{269}\). Section 15(2) of the Indian Medical Council Act of 1956 states any person who possesses required qualifications and is enrolled as a medical practitioner on the State Medical Register. If a person practices medicine without possessing either the requisite qualification or enrolment under the Act, he becomes liable to be punished\(^ {270}\).

The State Medical Council Act excludes from the purview of ‘medical practitioner’, one who practices veterinary medicine or surgery or Ayurvedic, Unani, Homeopathic or Biochemical system of medicine\(^{271}\). A person who is registered under Homeopathic Practitioner Act must practice homeopathy only, and he cannot be registered under the Medical Council Act because not possessing required qualification. Similarly, a person possessing required qualification as stipulated in the Medical Council Act cannot be registered as a medical practitioner under the Homeopathic Practitioners Act. He is under a statutory duty not to enter the field of any other system of medicine. If he trespasses into a prohibited field, his conduct amount to actionable negligence as the duty of care is breach by him.

Any person who does not have knowledge of particular system of medicine but practices in that System, is called ‘quack’, mere ‘pretender’ to medical knowledge or skill or a ‘charlatan’\(^{272}\). In terms of medical negligence, the duty of care is owed by all categories of health carers such as Allopathic, Homeopathic, Ayurvedic practitioners, nurses, physio therapist irrespective of their experience. In Dr. S.N. Namboodri Vs Haneefa\(^ {273}\), the practitioner of Ayurvedic System of medicine prescribes some Allopathic and Ayurvedic drugs along with urine test to treat a child for jaundice. No improvement occurs and the child dies in the civil hospital. It was found that, the defendant-practitioner possessed DMS in Ayurvedic but practiced allopathic system of medicine, which is a breach of duty of care owed to the public.

\(^{269}\) AIR 1996 SC 2111.
\(^{270}\) Section of 3 of the Medical Council Act 1956.
\(^{271}\) Section 2(d) the Maharashtra Medical Council Act, 1965.
\(^{272}\) Supra n 217.
3.4.2.1.5. The Duty of Care and Hospitals

Until the 20th century there were few duties incumbent on the hospital authority, the hospital was essentially the location where surgeons came to train and practice their skills. Today, in the era of new and innovative technology, the duty of care is imposed upon the hospital towards patients, visitors, and its own employees beside possess the required facilities.274

The existence and scope of the duty of care of the hospital are as follows: a) to employ those who are suitably qualified for the desired task and competent to perform that risk in the hospital. Allied to this, there is a duty for the hospital to make arrangements to see that staffs are effectively supervised in what they are entrusted to do;275 b) there is a primary duty on the hospital to provide a system of operation that is safe in terms of its employees and the patients who enter it; and c) the hospital has a duty to provide proper facilities and equipments in the hospital.276

Recently, there has been a great deal of debate regarding the extent of these duties in a regime where there is limited resource to fund the medical care. One of the grounds for medical negligence litigation is lack of required facilities for the safe operation task in hospitals.277 In a classical case of Wilsher Vs Essex Area Health Authority, court expresses its indignation at the way in which the hospital is run by the authorities by stating that it is the responsibility of the authority which runs the hospital to provide doctors of sufficient skill and experience to give the treatment offered, failing which, the hospital is directly liable to the patient. Non-availability or limited available fund will not reduce the duty of care of the hospital. However, in the academic circle, the discussion is going on the issue of whether the hospital authority owes primary duty to provide a reasonably safe and effective care notwithstanding the limited funds availability.


278 (1987) QB 730 CA.
3.4.2.1.6. Limits of duty owed to the patient

A medical practitioner is not under a legal duty to act gratuitously or voluntarily, therefore, he is not mandated by law to treat the injured who is not a patient or not presented to a hospital. If however, a doctor offers service for reward or free of charge, a duty of care will be thrust upon him. In the Australian case of Goode Vs Nash\textsuperscript{279}, the plaintiff presents himself for eye-testing. The tests are free; the doctor who is an experienced general physician offers service free of charge. The plaintiff suffered when the doctor placed hot tonometer upon his left eye and the loss of vision. Here, the doctor breached his duty to take care irrespective of fact whether he did it for rewards or not. The duty of care is owed by even non-qualified persons who hold themselves out as qualified or claim to have a particular medical or healing skill\textsuperscript{280}.

In Baleshwar Prasad Vs Firtu Das Manani\textsuperscript{281}, a child with fever was taken to a Registered Medical Practitioners clinic for treatment, where in his absence, his brother acting as a compounder injected two medicine and advice the patient to get treated in other hospital. Immediately, the child was brought to the General Hospital where declared the child brought dead. The appellants are not qualified to act as a doctor and compounder respectively to treat the ailing patients, yet, the court held them breach of duty of care.

3.4.2.1.7. Duties and Emergencies

Another key point on the requirement of ‘duty of care’ in the issue of medical negligence is, when the duty of care arises in emergency cases. Is it necessary to establish the doctor-patient relationship, before incurring the duty of care? The well established rule states that once the health carer accept the patient for treatment, it is the duty to use reasonable care and skill to him\textsuperscript{282}. Acceptance implies undertaking the duty irrespective of consideration, the duty arises where the hospital accept the patient for treatment. However, the point is whether the hospital is bound to accept the patient for treatment. This question is encountered in Barnett Vs Chelsea and

\textsuperscript{279} (1979) 21 SAST 419 (SC).
\textsuperscript{280} Brogan Vs Bennet (1955)All ER 199; Markham Vs Abraham (1911)1 BMJ 703.
\textsuperscript{281} II (2003) CPJ 457.
\textsuperscript{282} (1951)2 KB 343.
Kensington Hospital Management Commitee\footnote{283} three night watchmen who after having tea fell ill and started vomiting; they walked into the casualty department of the defendant-hospital which was opened at that time. The nurse on duty telephoned to the casualty doctor who told the nurse by telephone that they should go home and meet their doctors on the next day. But they did not go home, in the meantime, one of them died. The question for the court’s consideration: whether there was a relationship as a matter of law between the three night watchmen and the hospital staff and what the action could have been taken by the casualty-doctor in a situation of this kind.

The court found that the duty of care was breached by the failure of the doctor in attending the poisoned patients. The casualty doctor should have arranged to see them personally or at least refer them to some other medical practitioner to attend and make a proper diagnosis. However, the court does not articulate in general terms when such an ‘undertaking’ or ‘duty to treat’ comes into existence. The critiques point out that the casualty-doctor could be abused from time to time, there was no automatic duty on casualty staff to treat all who present themselves as it would impose unduly onerous and financially disastrous\footnote{284}. If the Bernett case were followed, a simple case would become an unusual case, for instance, in Barnes Vs Crabtree\footnote{285}, the plaintiff alleges that on Christmas Day she was not feeling well, hence, the doctor should perform surgery, inspite of the plea of the doctor that surgery could not be performed on Christmas day and her name was not on his list. The result of this refusal was, she lay down on the doorstep of the theatre until the police were called to remove her. On perusal of the evidence a fact came to light that she was quite well and disagreed to consult another. The court focussed on the following statement of law:

“ In a case of real acute emergency a doctor under the National Health Service\footnote{286}, under an obligation to treat any patient who was acutely ill; for example some one seriously injured in motor accident. The obligation of a doctor was to render all necessary and proper care he

\footnote{283} (1969)1 QB 428.
\footnote{284} Supra n 236.
\footnote{285} (1955)2 BMJ 1213.
\footnote{286} Similar to hospitals run by the State.
had to exercise reasonable skill in diagnosis. However, it did not mean that he was required to make a full clinical examination every time the patient asked for it.  

The court to some extent attempted to formulate the guidelines when duty of care arises and the scope of undertaking the responsibility in real emergency case. These obligations are limited to doctors who are serving in the government or the state owned hospitals. The judgment does not speak of the obligation of the doctors who are engaged in private practice of medicines where the fee or consideration is paramount.

What is apparent from the discussion is that with the complexity of modern medical practice the issue of the ‘duty of care’ remains as vague. English common law courts and Indian courts have been unable to identify the scope of the obligation of the health carer and the circumstances in which a duty of care exists also remains fluid. There is also no specific formulation as to when the duty of care may be undertaken by the doctor, dentist, physiotherapist, nurse etc., It appears as it depends on facts and circumstances of the particular case. Beside, the study of judicial precedents demonstrates the health carer owes a duty of care to patients and third persons who are likely to be affected by the acts of the health carer. How far such a proposition is justifiable in terms of professional relationship is a debatable issue.

3.4.2.2. BREACH OF DUTY OF CARE: “STANDARD OF CARE”-Reasonably skilled doctor

Hitherto intricacies of the duty of care which may arise were considered along with the physician-patient relationship in the context of medicine. Whatever may be the complexities as to the scope of duty of care; the presence of duty of care is obvious and admitted by the medical professionals. The failure of the practitioners in discharge of duties as warranted by law constitutes ‘breach of duty’. In this context negligence is defined as “breach of duty of care”. But the issue of breach duty throws several questions, say, what is the standard of care? What is the test determine the standard of care? How to identify the degree of care? It should be considered that, there is no breach of duty unless the health carer has failed to meet the standard of

\[287\text{Ibid.}\]
care required by the law in the context of the duty that exists to take all reasonable care. The expert evidence plays very significant role in proving how the health-carer has failed to come up to that standard. The usual standard adopted in the tort of negligence especially in non-medical negligence case, is the standard of the ‘reasonable man’ which is an objective standard but the moot point is, can the same standard be adopted where the defendant is possessed professional skill and knowledge, because the reasonable man does not have that skill. Therefore, the present part of the thesis focuses on the issue of breach of duty in terms of the standard of care.

3.4.2.2.1. Reasonableness: Reasonable man

It is argued that the basic test for negligence would be whether the defendant’s conduct was reasonable in all the circumstances of the case. Reasonable conduct is not negligent; while unreasonable conduct is culpable. The criteria to determine “reasonableness” should be objective standard; as such it does not take into consideration the subjective attributes of the particular defendant. However, the concept of reasonableness has not been defined, since it is not being defined, it has become difficult to understand and adopt in the case of negligence. Suggesting some words like the standard of the ordinary man, the average man or the man on the Clapham omnibus as equivalent of the reasonableness are confusing.

3.4.2.2.2. Reasonably skilful doctor: Bolam test

In the context of medicine, the very important point to be considered relates to the question: what is the standard of care which is expected of the doctor? Mc Nair J, provides the classic answer in the famous case of Bolam Vs Friern Hospital Management Committee quoted as under:

“Where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of man on the top of a Clapham Omnibus, because he has not got this special skill. The test is the standard of

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288 Supra 175 p. 335.
289 Supra note 2.
290 Glasgow Corporation Vs muir (1943) AC 448, 457.
291 Hall Vs Brookland Auto Racing Club (1933)1 KB 205, 217.
292 (1957)2 All ER 118; (1957)1 WLR 582 at 586.
the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is a well-established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art.²⁹³

According to this ruling, the standard of the doctor should be not assessed on the line of the ordinary man or man on the Clapham omnibus but the standards of the ordinary skilful doctor. He is the practitioner who follows the standard practice of his profession or follows practices which are approved by the responsible opinion within the profession; he has reasonably competent to grasp medical techniques, and is aware of the medical development as the average competent doctor would expect to be; the circumstances in which a doctor treats his patient.²⁹⁴

One of the characteristics of the reasonably skilful doctor is, his duty to update his knowledge about major developments in practice but it does not mean this duty extends to the requirement that he should know all developments happening in the particular area of medicine. He is not expected to achieve the same result as a doctor who is working in ideal conditions with all facilities. It is sufficient if he possess the ordinary skill of an ordinary competent man in the particular profession. However, the critique points out that Bolam test has failed to make the distinction between the standards of the ordinary skilled doctor and the reasonably competent professional. The former places emphasis on the standards which are infact adopted by the profession, whereas the latter makes it clear that negligence is concerned with the failure to do what ought to have been done in the circumstance which is measured by reference to the hypothetical ‘reasonable doctor’.²⁹⁵ It is for the court to decide what a reasonable doctor would have done, and not the peer members of the profession. The Bolam test has failed to identify this fundamental distinction and the same has been ignored as irrelevant in the vast majority cases.²⁹⁶

²⁹³Ibid at p. 121.
²⁹⁴Supra note 177.
²⁹⁵See Montrose " Is Negligence an Ethical or Sociological Concept ?" (1958) 21 M.L.R 259
Similar formulations of standard of care required of the medical profession are found in other commonwealth countries. In Canada, one of the most widely accepted statement of law is that of Schroeder JA in *Crits Vs Sylvester*:

“Every medical practitioner must possess a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.”

This standard also allows for differences of view within the medical profession. In *Lapointe Vs Hospital Le Gardeneur*²⁹⁸, it was observed that the standard which could reasonably be expected of a “normal, prudent practitioner of the same experience and standing” is potentially misleading since inexperience is not a defence. Here also, there is no clear demarcation between the ordinary doctor and the reasonably competent doctor. The court assumption that standard of the expression - the ‘reasonable man’, the ‘average’ man or the ‘ordinary’ man would be in essence the same, hence, it draws a lot of criticisms.

3.4.2.2.3. **Degree of Care**: Ordinary skill of an ordinary competent man – reasonable care:

The standard of care in medical profession is to be judged by the standard of the ordinary skill man exercising and professing to have that special skill²⁹⁹. The approach followed by the Canadian courts is that the work of a specialised nature should possess higher standard of care, than the one who does not have skill by special training and ability. Thus, the standard of care of a specialist is higher than the ordinary skilful specialist³⁰⁰. English common law does not demand the highest standard of care and skill for highly specialised kind of work within a particular profession. It is sufficient if the practitioner exercise the ordinary skill of an ordinary competent man exercising that particular art.

²⁹⁷ (1956)1 D.L.R. (2d) 502, 508.
²⁹⁹ See Bolam’s case.
³⁰⁰ Bails Vs Boulanger (1924)4 D.L.R 1083; Poole Vs Morgan 1987 BWWR 217.
3.4.2.2.4. Pre – Bolam Test: Historic evolution of the standard of care

Mc Nair J. the architecture of the Bolam test: the degree of skill in issue is the ordinary skill of an ordinary competent profession and not that of the highest, owes its origin in the dictum of the nineteenth century held in Seare Vs Prentice\(^{301}\), the plaintiff who fell from a horse sustained fracture of his arm. The defendant surgeon applied vinegar and wrapped the wounded arm with the tape thinking that arm was swollen and not broken. Sometime later the surgeon set the elbow, but the plaintiff continued in a crippled state until it was cured by another surgeon. The plaintiff sued the defendant for negligent, ignorant and unskilful treatment. The court held that a surgeon must achieve an ordinary skill of surgeons, failure to achieve or bring in to the profession a proper standard of care, constitutes negligence. Careless, ignorance and unskilful treatment constitutes different ways of failing to achieve an ordinary skill of surgeons.

Since this decision, the term “reasonable skill and care” has been frequently applied by the courts in deciding action for medical negligence. The test emphasises that doctors do not guarantee a desired result out of their efforts. They do to the best of their abilities as reasonable doctors can do in the circumstances of the case. A medical practitioner is not an insurer, who guarantees to compensate the loss, if something happens. A medical practitioner is not responsible and cannot be blamed if something goes wrong, because, things may go wrong in the treatment of a patient even when the doctor exercise highest possible care and skill. The obligation of the doctor is not to guarantee a favourable outcome, but exercise reasonable care. This view has reflected in the judicial statement of the law in Hanke Vs Hooper\(^{302}\), the plaintiff suffers from considerable swelling and discolouration of the arm and is forced to be in bed for a month as a result of operation performed by the defendant. The plaintiff alleges negligence on the ground of failure to heal him. Justice Tindall CJ, observes: a surgeon cannot be an actual insurer; he is only bound to display sufficient skill and knowledge of his profession. The surgeon is not guilty of negligence if it is proved that all the acts done by him are consistent with the proper performance of the operation. The plaintiff must show that the injury was attributable

\(^{301}\) (1807)8 East 348.
\(^{302}\) Hanke Vs Hooper (1835)7 C&p 81, 84 Per Jindal CJ.
to want of skill, want of reasonable care and skill is breach of duty of the medical man.

Again, within three years in another case Lanpheir Vs Phipos[^303], Justice Tindall CJ, rules that: “every person who enters into a learned profession undertake to bring to the exercise of it a reasonable degree of care and skill. He does not undertake that he perform a cure; nor does undertake to use the highest possible degree of care. There may be persons who have higher education and greater knowledge and greater advantages than he has, but he undertakes to bring a fair, reasonable and competent degree of skill.”. This view shows that a medical practitioner should not be judged by the standards of the most experienced, most skilful or most highly qualified member of the profession, but by reference to the standards of the ordinarily competent practitioner nor the practitioner should be judged by the standards of the least qualified or least experienced, if he is failed to reach this objective standard of the ordinarily competent and careful doctor, he is negligence. In Rich Vs Pierpont[^304], the plaintiff a pregnant woman was admitted in the hospital for the safe delivery of a child. The doctor administered some gin to the plaintiff inspite of her aversion to the use of spirits. As a result the delivery proved abortive, the child being dead in the womb. The question was whether there had been a want of competent care and skill on the part of the doctor, whether the doctor should have exercised greater care and skill. It was held that it was not enough to the defendant liable because some medical men of far greater experience and ability might have used a greater degree of care, only a want of competent care and skill that attributed to negligence.

An echo of the statement on the reasonable care can be found in R Vs Bateman[^305], wherein the court explained that if a person who represents himself as possessing special skill and knowledge, is consulted by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment…[^306]. The jury should not exact the highest, or very high standard nor should they be content

[^303]: (1838)8 C&P 475.
[^304]: Earle CJ (with jury) (1862)3 F&F 35.
[^305]: Supra 213.
[^306]: Mahon Vs Osborne (1939)2 KB14, 31, per scout L.J. “To fall short of perfection is not the same thing as to be negligent”; Daniels Vs Heskin (1954) I.R. 73, 84.
with a very low standard. What the law requires a fair and reasonable standard of care and competence.\(^{307}\)

In *Vancouver General Hospital Vs Mc Daniel*,\(^{308}\) the plaintiff was suffering from diphtheria. At that time there was a small pox in the town and some small pox patients in the hospital. The hospital policy to tackle this situation was by a system of sterilisation rather than isolation. The plaintiff was diagnosed as suffering from small pox and suffered personal disfigurement. The plaintiff sued the hospital alleging negligence in placing the small pox patients on the same floor where the plaintiff was and in allowing nurses who nursed small pox patients attend on her. Again the question arose as to standard of care of the hospital. The court observed that a defendant charged with negligence has to clear himself by showing that he has acted in accord with the general and approved practice. The system adopted by the hospital was in accord with general practice approved by the medical professional body, even though it was not universal practice in Canada and US. The hospital had established this and it was not liable. This statement was approved by the House of Lords in *Whiteford Vs Hunter*,\(^{309}\) where it was observed that once actions of the medical practitioner conform to the proper professional practice of the time, he is not guilty of negligence.

Lord Denning is very much concerned with medical practitioner, and warns against the approach of the court in awarding damages for the plaintiff/patients out of sympathy or just because the patient suffers as a result of the act done by the practitioner. **Lord Denning** apprehends that lenient view for the patient without finding fault on the part of the practitioner would lead to defensive medicine in the event of which it will be a great loss to the community at large. In *Roe Vs Minister of Health*,\(^{310}\) Lord Denning observed:

> “One final word. When two persons have suffered terrible consequences, there is a natural feeling that they

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\(^{307}\) Per Lord Hewart C.J., approved in Gent Vs Wilson (1956)2 DLR (2d) 160 Ont. CA and Parkin Vs Kobrinksy (1963)46 WLR 193 (Man. CA).

\(^{308}\) (1934) 152 LT 56, 57-58, (PC); Marshall Vs Lindsay Country Council (1935)1 KB 516, per Maugham LJ.

\(^{309}\) (1950) WN 553 (HL).

\(^{310}\) (1954)2 QB 66, (CA).
should be compensated. But we should be doing a
disservice to the community at large if we were to
impose liability on hospitals and doctors for every thing
that happens to go wrong. Doctors would be led to
think more of their own safety than of the good of their
patients. Initiative would be stifled and confidence
shaken... We must insist on due care for the patient at
every point, but we must not condemn as negligence
that which is only inadventure311.

The obiter dictum expressed by Lord Denning makes crystal clear that the
Lord Denning unwillingness to impute negligence on the part of the medical
practitioner, and his sympathetic approach towards medical profession rather act
objectively. Lord Denning draws a thin line of difference between negligence and
misadventure. If the patient suffers as a result of the treatment undertaken by the
practitioner cannot be held as negligence unless he falls below the standards of the
ordinary skilful and competent member of the medical profession. On the other hand,
the patient’s illness aggravates or shows no sign of improvement with no fault of the
treating doctor, it will be ‘misadventure’ for which the doctor is not liable. In
Hatcher Vs Black and others312, the plaintiff had been suffering from goitre, the
surgeon who diagnosed her a toxic goitre, discussed with her regarding possible
alternatives, an operation in hospital or medical treatment with drugs, and need of
long time in case patient opt for medical treatment with drugs, but he did not spell out
the fact that there was slight risk to her voice involved in the operation.

The surgeon as per the wishes of the patient performed on her a partial
thyroectomy at the hospital. But her left vocal cord was paralysed and alleged
negligence in the operation. Lord Denning, rejecting the charge, states even if the
surgeon had told her the result would not have changed; the law did not condemn a
doctor when he did what he considered as wise and appropriate. The damage to the
vocal cord was a well known hazard in such an operation, notwithstanding care, and
diligence. This is not negligent. Hence, the non-disclosure of risk involved in the
treatment does not constitute breach of duty of care.

311 Ibid.
312 (1954) Times, 2 July Per se the Lord Denning.
The issue of standard of care in terms of existence of different professional practices attracts the attention of the court again in *Hunter Vs Hanley*\(^{313}\), the plaintiff suffers from chronic bronchitis, the doctor who examined him prescribes a course 12 injections of procaine pencillin. During the 12\(^{th}\) injection, as the doctor withdraws it the needle breaks, the end part remains embedded in the patient’s body. The plaintiff alleges ‘gross negligence’ on the ground that the doctor has failed to use a suitable hypodermic needle. The issue before the court: what should be the standard of care of the doctor where there are different professional practices in the field of treatment? Here, it is necessary to consider the observation of Lord president Clyde: “in the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly not negligent merely because his conclusion differs from that of other professional men nor because he has displayed less skill or knowledge than others would have known. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care\(^{314}\).” Where the opinion of experts is divided over the method or procedure of treatment, the benefit of doubt goes to the medical man. Lord Clyde has discarded the fact that standard of care allows difference of view within the medical community and therefore, it has to be decided by the court.

The principles laid down by the court in the process of evolution of the standard of care as discussed in the above have been reiterated and re-affirmed by the common law court in the famous and historical case *Bolam Vs Friern Hospital Management Committee*\(^{315}\) which set the new precedent in the matter of medical negligence. In this case, the plaintiff who suffered from mental illness was treated with electro-convulsive therapy. The defendant did not warn the plaintiff of the slight risk of bone fracture. During the course of the administration of this, in accordance with the hospital’s normal practice the doctors did not administer a muscle relaxant drug nor applied sufficient manual restraint. The plaintiff’s bilateral hip fractured. His contention was the doctor had been negligent on three accounts, first in not giving

\(^{313}\) (1955) SC 200, 1955 SLT 213; Per the Lord President Clyde.

\(^{314}\) This decision followed by the Supreme Court of Ireland in Dunne Vs National Maternity Hospital (1989) I R 91, 109.

\(^{315}\) (1957)2 All ER 118, Per Lord Mc Nair J.
him relaxant drugs which admittedly would have excluded the risk of fracture; secondly, if drugs not used, in failing to provide sufficient manual restraint; finally, in not warning him of the risks involved in the treatment.

At the time of this treatment, there were two different opinions in the medical field as to whether the plaintiff should have been given relaxant drugs and whether he should have been given warned. One school of thought considered that some sort of control, whether manual or by way of administration of drugs, should be used. The other school found that such an approach was potentially dangerous. The court found the defendants not liable for negligence. In directing jury McNair J said:

a) The standard of care in general is that of the ‘reasonable man’ the man on the Clapham Omnibus; but in the context of medical profession, the test is not the test of man on the top of a Clapham Omnibus, because, he has not got this special skill. The true test is the standard of the ordinary skilled man exercising and professing the have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

b) A doctor is not guilty of negligence, if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art; in this context, negligence means “failure to act in accordance with the standards of reasonably competent medical men at the time”.

c) Where the evidence shows difference of opinion that is some doctors uses relaxant drugs; some uses manual control and some neither, the doctor in the instant case was not negligent because he had used neither.

The Bolam’s case, since its decision has operated as an authority in deciding any dispute in relation to the duty of health-carer, not only in England but also in India. In view of the straight forward test, it is appropriate to focus on the area where the Bolam test applies and how it gives rise to interpretation in the context of medicine. The case traverse into areas where issue concerns with the question of

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316 The court approved the statement held in R Vs Bateman, (1925) 19 Cr. App. R.8; Mahon Vs Osborne, (1932)2 KB 31.
317 The court approved the statement held in Vancouver General Hospital Vs Mc Daniel (1934) 152 LT 56, 57-8, (PC); Marshall Vs Lindsey County Council (1935)1 KB 516, 540.
318 Quoted from the Scottish case of Hunter Vs Hanley (1955) SC 200.
treatment, diagnosis, disclosure of information, medical interest of the patient where a
person medically incompetent to consent and causation etc.,

3.4.2.2.5. Standard of Care Required: General Principles-

3.4.2.2.5.1. Normal Orthodox Practice:

As a general rule, where the defendant proves that he has acted in accordance
with the normal practice which is accepted and followed by other medical
practitioners in a similar situation will be strong evidence to the defendant that he has
not been negligence. Rationality behind the acceptance of common practice is the
presumption that no professional man/body blindly adopts a systematic practice which
does not ensure safety of others. However, following a normal orthodox practice is
only ‘evidence’ and not ‘conclusive proof’, as such the court may find that practice is
itself negligent. There are many reasons why a particular practice is commonly
followed such as convenience, cost, or habit which have no bearing upon acting as
reasonable prudent against potential harm to others. This is what is known as
‘customary test’. The point to be considered at this juncture: whether the customary
practice followed or adopted in non-medical profession can be applied in an action for
medical negligence. For the first time, this test has been applied by the court in
Vancouver’s and Whiteford’s case. In Bolam’s case approved the customary test in
terms of stating that the doctor has acted in accordance with a practice accepted as
proper by a responsible body of medical opinion is not negligent.

a). Complying with professional practice:

Under the ‘Bolam’ test, it is not negligence where the doctor demonstrates that
he has complied with practices which a competent body of colleagues accepted it as
proper. The first controversial issue is: who decides whether what the doctor has
done complies with that standard of practice? What is the relevant evidence of
common practice? What evidence counts? How many experts are needed? One could
answer confidently that as it is one of law, it would be for the judge to decide the
establishment of standard of care of the doctor in a particular situation, and the doctor
in the particular circumstances has complied with the prescribed standard. For this

319 Morton Vs William Dixon Limited (1909) SC 807; Morris Vs West Hartlepool Steam Navigation Company
Limited (1956) AC 552, 579.
320 Cavanagh Vs Ulster Weaving Company Limited (1960) AC 145; Robert Vs Bolduc (1991) 78 DLR 4th 666,
710 (SCC).
purpose, the court as a matter of fact relies upon the medical evidence. When the court acts upon the medical evidence, it is virtually the doctors who decide what the doctor in question ought to be. The development of the case law on medical negligence reveals that it is the doctor’s approach that will be adopted therefore; the peer group of doctors decide both factual and legal issues\textsuperscript{321}. In effect, it is nothing but a way of handing over the court’s jurisdiction to the professional colleagues.

What is the evidence of common practice relevant?

The Bolam test does not deal with the circumstances where the evidence of medical expert is relevant. It should be noted that where the case does not involve difficult or uncertain questions of medical or surgical treatment, or abstruse or highly technical scientific issues the practice of experts will be largely irrelevant. On the other hand, in a case where there are difficult, uncertain, highly technical scientific questions requiring information not ordinarily expected of a practitioner and where the state of medical knowledge is highly variable between scientists, public health authorities and different medical communities, it is not appropriate for the court to adopt an approach which conform with the normal orthodox practice\textsuperscript{322}.

What evidence counts? Expert evidence!

The requirement of complying with accepted practice indicates that the court must be satisfied with the evidence and reached at the conclusion that there is a responsible body of professional opinion which support the practice in question. The evidence is simply an expression of opinion by an expert witness about what he thinks, what he would have done, had he been placed, hypothetically in the position of the defendant, it is of little assistance in determining whether there was a responsible practice\textsuperscript{323}. Moreover, it is always open to the court to reject expert evidence applying the ordinary principles of credibility that would be applied in the court, for instance, when the issue is contradictory or when the medical expert witness acts as an advocate rather than an impartial and objective\textsuperscript{324}.

\textsuperscript{321} Supra n 85 p 80.
\textsuperscript{322} Michael A Jones, Medical Negligence, (London: Sweet and Maxwell, 2003) p 206.
\textsuperscript{323} Chapman Vs Rix (1960); (1994)5 Med. LR 239, 247 Lord Goddard said that court cannot avoid a finding of negligence merely because two doctors state that they would have acted as the defendant did.
\textsuperscript{324} Dowdie Vs Camberwell Health Authority (1997)8 Med. L.R. 368, 375, Kay J observed that “mere fact that two distinguished expert witnesses have testified that it was within the range of acceptable practice to proceed in that may does not oblige me to accept their evidence, on this issue, I accept the evidence of the plaintiff’s expert…..”
How many experts?

In *Hill Vs Potter*\(^{325}\), **Hirst J**, denies the fact that the Bolam test allows the medical profession to set the standard of care: ‘in every case the court must be satisfied that the standard is upheld by a substantial body of medical opinion and this body of opinion is both respectable and responsible and experienced in this particular field of medicine’. The phrase ‘responsible body of medical men’ used in Bolam test is not clearly explained for instance, a body of 10 doctors specialised in spinal surgery, out of total over 1000 orthopaedic and neurosurgeons in the country, can it be considered as responsible body of opinion? What evidence supporting the defendant’s conduct should be treated as reasonable and logically defensible\(^{326}\).

Plaintiff in great disadvantage:

The inherent danger in the Bolam test is relying upon the evidence of medical expert in deciding the issue: whether the doctor has acted in accordance with a practice accepted as proper by responsible body of medical men skilled in the particular art, if the expert witness shows the professional bias in favour of a professional colleague or fails to act impartially and objectively, it would place the plaintiff-patient in a profound disadvantage or hardship and leave the plaintiff ultimately as helpless because of want of medical expert evidence. The Bolam test may be used to cover a vast array of professional activity in medicine\(^{327}\).

b). *Differences of opinion*:

It has been argued that there are numerous cases in which actions for medical negligence have been dismissed on the ground that the doctor has conformed to an ‘accepted practice of the profession’, so long as doctor acts in a manner acceptable to the medical profession and attends the patient is no negligence\(^{328}\). A doctor is not negligence if he has acted in accordance with the practice accepted as proper by responsible doctor skilled in that particular field. Where there is more than one common practice, as the Bolam test contemplates compliance with one of the

\(^{325}\) (1983)3 All E.R. 716, 728.


\(^{328}\) See Vancouver’s case n 313; WhitefordVs Hunter, (1950) WN 553; Bolam’s case n 223; Anjana Varma Vs Dr. Ashok Kumar II(2003) CPJ 210; Rajkumarbai & another Vs Dr. R.R. Dhoot Hospital II(1999) CPJ 682.
practices or methods will normally excuse the defendant. Where the opinion is divided over the issue of negligence, the court instead of deciding legally and logically, it tries to distance itself from the issue. The clear example of House of Lords distancing itself from the issue where there is conflict of opinion between two schools of thought is *Maynard Vs West Midlands Regional Health Authority*\(^{329}\), where there was a difference of opinion between the two peer groups of professional body as to whether the decision to operate on the patient was appropriate. The court of the first instance accepted the evidence of one body of medical expert, and held that the defendants were negligent. On appeal the House of Lords overturned the decision by holding that: “a judge’s preference” of one body of distinguished professional opinion over another which is also professionally distinguished, is not sufficient to establish negligence in a practitioner whose actions have also received the seal of approval. If this was the real reason for the judge’s finding, he erred in law even though elsewhere in his judgment he stated the law correctly. In the realm of diagnosis and treatment, negligence is not established by preferring one respectable body of professional opinion to another. The failure to exercise the ordinary skill of a doctor is necessary\(^{330}\).

In *Sidaway Vs Board of Governor of the Bethlem Royal Hospital*, there was difference of opinion about the extent of disclosure of information to the patient. In this case, the plaintiff was complaining of very persistent pain in the right hand and shoulder and also pain in the left forearm. The doctor decided to operate based upon the Myctogram which disclosed that the pressure on the fourth nerve root was the cause of pain. During the operation, the plaintiff’s spinal cord was damaged and she suffered severe disability. The plaintiff does not allege that the operation had been negligently performed, but claims the ‘failure to warn of the risk’ of damage to the spinal cord. The operation involves two specific risks, damage to nerve root and damage to the spinal cord. The evidence of the expert witness shows that the risk of damage to spinal cord alone which is more serious risk, happens less than one percent. The medical witness further opines that it was a practice accepted as proper by a

\(^{329}\) (1984)1 WLR 634 where it was held that the court will not choose between the different opinions of responsible bodies of physicians.

\(^{330}\) Ratty Vs Haringly Health Authority (1994)5 Med. L.R. 413, 416. (CA).
responsible body of competent neuro-surgeon not to frighten a patient by talking about death or paralysis. Lord Scarman said:

“The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is matter of medical judgment.”

The court considered the Bolam test in deciding the issue whether non-disclosure of risk in a particular case should be condemned as a breach of the doctor’s duty of care. It is also apparent from the above statement of law that it is an issue to be decided primarily on the basis of expert medical evidence. However, Lord Scarman himself recognised “the implications of this view of the law disturbing. It leaves the determination of a legal duty to the judgment of doctors”. The interpretation of the Bolam test was not accepted by Lord Bridge who said: “if there is a conflict of evidence whether a responsible body of medical opinion approves of non-disclosure in a particular case, the judge will have to resolve that conflict.

The critiques persistently argue that the doctors themselves should decide what the standard of care is. Where division of opinion and practice exists, the court should appreciate the opinion of one body and conclude the other as incorrect. A judge may substitute his own assessment of risk for that of medical opinion or where it can be demonstrated that the profession as a whole or supposedly responsible body of within it have failed to take into account some relevant factor or that some underlying public policy requires them to change their standards. Outside the context of medical negligence actions, the court applies the notion that commonly adopted practices may themselves be negligent, for instance, in the case of employer’s

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331 (1985) AC 871, 881. emphasis added; Sir John Donaldson M.R. in the Court of Appeal, (1984)1 All ER 1018, 1028: “The definition of the duty of care is a matter for the law and the courts. They cannot stand idly if the profession, by an express of paternalism, denies its patient a real choice. In a word, the law will not permit the medical profession to play God.”
332 Ibid at p. 900.
334 Neilson Vs Basidon of Thurrock Health Authority (1991) QBD; unreported cited in Michael A Jones, n 318 p 198
liability\textsuperscript{335} and cases involving professional liability\textsuperscript{336} where the court rejected the proposition that a bank is not negligent if it takes all the precautions usually taken by bankers. A practice which was widely followed could be negligent because it had inherent risk which would have been foreseen by a person of reasonable prudence, there was no need to take into account as the same practice was not conclusive evidence\textsuperscript{337}. The commentator points out that there is no basis for applying a different rule about effect of complying with common practice to the medical profession from that which applied to all other professions. The decision as to what constitutes negligence for court to determine\textsuperscript{338}.

In an attempt to encounter criticisms, the English courts have held that compliance with common practice was negligent. In \textit{Huck Vs Cole}\textsuperscript{339}, the plaintiff was suffering from fulminating septicaemia, the doctor neither administered a course of pencillin treatment nor prescribed antibiotics to her. Consequently, the plaintiff voice was permanently impaired. Medical literature provides for difference of opinion over the conduct of the doctor. \textbf{Lord Denning} said: “the defendant cannot be held liable for taking one choice out of two or favoring one school rather another. He is negligent only when he falls below the standards of a reasonably competent practitioner in his field”. If the evidence shows that existence of lacuna in the professional practice, however the small risk may be, the court must examine that lacuna. If the court finds analysis of reasons given, not reasonable in the light of current professional knowledge, there is no proper basis for the lacuna, the court function is to state the fact and declare it constitute negligence. By doing so, the practice will be altered to the benefit of the patient\textsuperscript{340}. However, the case where the Bolam test has been doubted is \textit{Joyce Vs Merton and Wandsworth Health Authority} represents that is not the pioneer group of medical profession but the court who decides

\begin{footnotesize}
\begin{itemize}
\item Cavanagh Vs Ulster Weaving Compnay Limited (1960) AC 145; Morris Vs West Hartlepool Steam Navigation Company Limited (1956) AC 552; Stokes Vs Guest, Keen and Nettlefold (Bolts and Nuts) Limited (1968)1 WLR 1776, 1783.
\item Llyods Bank Vs Savory and Company (1933. AC 201, 203)
\item Edward Wong Finance Company Limited Vs Johnson, Stokes and Masters (1984) AC 296
\item Supra n 175 p 342.
\item (1993)4 Med. LR 393 at 397, decided in 1968
\item Thoms J comments in Wiszniewski Vs Central Manchester Health Authority (1996)7 Med. LR 248 at 261, “judge should not preclude himself from reaching that conclusion simply because clinical judgment is involved.”
\end{itemize}
\end{footnotesize}
whether the defendant conduct conformed with the common practice of medicine. If the practice itself, appears to be unreasonable, the defendant will be negligence\textsuperscript{341}.

**Bolitho Vs City and Hacking Health Authority\textsuperscript{342}**: New Bolam Case a two year old child suffered brain damage due to cardiac arrest caused by an obstruction of the bronchial air passages. The plaintiff’s experts contended that the disastrous outcome could have been avoided if child had been intubated. The defendant acknowledged that the doctor had breached his duty by failing to attend the child but the expert opined that he would not have intubated the child even if he had attended. The issue was whether it was appropriate to intubate the child in the circumstances of the case. Here, the defendant places his reliance on Bolam test. However, the court held that before accepting a ‘body of opinion’, it satisfied itself that whether the opinion had a legal basis, which would involve the weighing of risks against benefits in order to reach a defensible conclusion. The clear interpretation of the Bolitho’s case suggests the following propositions of law:

1) The court decides whether the opinions held by the competent medical expert are reasonable or not. It is a wrong to allow the assessment of the risks and benefits as exclusively matter of clinical judgment. Just because issue involves clinical judgment, the court should not hesitate to examine the rationality of the opinion\textsuperscript{343}.

2) The court has power to reject expert evidence applying the ordinary principles of credibility that would be applied in the court-room\textsuperscript{344}.

3) It is not sufficient for the defendant produce expert witness in support of his contention that what he had done or not done was in accordance with the accepted clinical practice\textsuperscript{345}.

4) The professional practice is the strong evidence of the exercise of reasonable care but ultimately it is for the court to decide what constitute negligence.

Some commentators point out that the Bolam test has no relevance in the Bolitho’s case where the issue concerned with the causation. The ruling of *Bolitho* devalues the trump card which Bolam brought into the medical profession. It is also undesirable to undermine the standard test beyond a certain point. Bolam provides some protection for the innovations in the field of medicine, if this protection is

\textsuperscript{341} (1996)\textsuperscript{7} Med. LR.

\textsuperscript{342} (1997)\textsuperscript{4} All ER 771 (HL) decided in (1993)\textsuperscript{4} Med. LR 381, 392; (1993) PIQR p 334 the court reserves the right to decide that a responsible body of physicians would not accept the practice as proper.

\textsuperscript{343} Supra note 336.

\textsuperscript{344} For example, expert evidence that simply support the profession may be treated as less credible, see Murphy Vs Wirral Health Authority (1996)\textsuperscript{7} Med. LR 99.

\textsuperscript{345} The principle derived from Huck Vs Cole see n 335.
removed, then it will have inhibiting effect on medical progress. In fact it would be very difficult for a judge to reach conclusion that views genuinely held by the competent medical were unreasonable. Nonetheless, Bolitho has been hailed as ushering in the New Bolam\textsuperscript{346}.

\textbf{Impact of Bolitho case:} In \textit{Marriot Vs West Midlands Health Authority}\textsuperscript{347}, the plaintiff who sustained head injury underwent various neurological tests conducted which showed that no sign of abnormality. Based upon the report, the practitioner advised the plaintiff stay back at home and consults him if the condition deteriorates. Some days later, the plaintiff condition deteriorated and following emergency surgery on a skull fracture, he was left paralysed and with speech disorder. It was alleged that the doctor ought to have referred the patient to the hospital for a comprehensive neurological examination. The failure to do was breach of his duty. The expert witnesses for the defendant stated that although in the circumstances, the other practitioner would have referred the patient to hospital, yet it was reasonable to leave the patient at home, with suitable advice. The court subjected the body of opinion to judicial analysis to see whether it was properly regarded as a reasonable by applying Bolitho case, weighed the small risk against the disastrous consequences for the plaintiff. The Marriot case moves the Bolitho test from one of logic to one which is more akin to the reasoning applied in non-medical standards of care decisions. However, Marriot does open an alternative rout to ‘New Bolam’.

3.4.2.2.5.2. Standard of Care: Indian Courts Approach

The courts in India have adopted the Bolam test in deciding issue relating to the breach of duty of care of the practitioner. The first case where the Bolam test had been widely discussed and applied was \textit{Dr. Laxman Balakrishna Joshi Vs Trimbak Bapu Godbole}\textsuperscript{348}. In \textit{Kusum Sharma Vs Batra Hospital and Research Centre} \textsuperscript{349}, it


\textsuperscript{348} AIR 1969 SC 128 Where the son of the petitioner suffered leg fracture in an accident, for which the defendant doctor, an orthopeudician did the reduction and put the injured leg into the plastic. Within four hour of the treatment the patient died. It was alleged that while reducing the fracture the doctor used manual traction and excessive force with the help of three men and such traction was not done under proper general anaesthesia. Hence, the defendant failed to act as reasonable competent man in the situation. The court followed Bolam test.
was held that the doctor is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Every surgical is attended by risks. One cannot take the benefits without taking risks. *In Rajkumar Agarwa Vs Mukhu Padhya*[^350], it was observed that where there are two genuinely responsible schools of thought about the method of treatment, courts should not place the hallmark of legality upon one form of treatment. Recently, in *Jacob Mathew Vs State of Punjab*[^351], the Supreme Court followed the test for determining whether there was negligence on the part of medical practitioner as laid down in Bolam’s case. But, there is no Indian decision where the accepted practice of the medical profession was condemned by the court for failure to meet the standard of reasonable care. Ostensibly, professional practice reflected in the medical evidence prevails over judicial timidity[^352].

c). *Department from Established Practice*:

Another issue involved in the medical negligence is, whether the doctor is bound to follow only the general accepted professional practice in the diagnosis and treatment of the patient? If the doctor deviates from medically approved practice, would it be imputed as evidence of negligence? How does the law view a doctor who complies with or deviates from accepted practice? It is indeed a situation where the practitioner faces a dilemma and forces to practice defensive medicine. If a deviation from common professional practice is considered as proof of negligence, then no doctor will be willing to introduce a new technique or method of treatment without facing the risk of a negligence action if something goes wrong. But sometimes a complete departure from accepted practice may provide overwhelming evidence of a breach of duty. Therefore, it is necessary to adopt a standard with the help of which one can answer the issue when the departure of common practice constitutes negligence or breach of duty.

Medical profession provides that a doctor should have the freedom in exercising his common sense, experience and judgment in the way decides to treat his patient. Just because, he did not comply with procedure as stipulated in the text book

does not establish negligence\textsuperscript{353}. What is material to establish that the defendant-doctor adopted a course which no physician of ordinary skill would have taken if he had acted with reasonable care? In \textit{Hunter Vs Hanley}, the court suggests some criteria to determine where the deviation from the normal practice may consider as ‘negligence’. First it must be proved that there is a usual and normal practice; secondly, it must be proved that the doctor has not adopted that practice; and thirdly it must be established that the course which he adopted is one which no other professional man of ordinary skill would have taken if he had been acting with ordinary care. However, these standards do not allow a medical practitioner to justify his action when he deviates from the medically accepted standards\textsuperscript{354}.

\textit{Breach of Duty of care:} In \textit{Chin Keow Vs Government of Malaysia}, a doctor gives to a patient an injection of pencillin without making any enquiry regarding the patient’s medical history. If history had been taken, he would have ascertained the fact the patient was allergic to pencillin. The patient as a result of this, became very serious and ultimately expired due to allergic reaction to the drug. It was revealed that the doctor was aware of the risk involved in the treatment, but did not take precaution because no such mishap had occurred before. He was held to have been negligent in not following the accepted standard of the medical profession\textsuperscript{355}.

\textit{Justification for deviation:} Where there was a departure from the normal practice of medicine which proves unsuccessful, such departure should be justified with scientific reason, failing which constitutes breach of duty of care owed to the patient. In \textit{Clark Vs Mc Lennan}, the plaintiff suffered from post-natal condition of stress incontinence for which the defendant-gynaecologist decided to perform what is known as an anterior colporrhaphy operation. Prevailing practice indicates that such an operation should not be performed until three months after birth because of risk of hemorrhage. This eventuality occurred resulting in break down of operation. The following points are taken into account: a) that there was general practice not to perform an anterior colporrhaphy until at least three months after birth; b) that one of the reasons for this practice was to protect the patient from the risk of hemorrhage

\textsuperscript{353} Per Streatfield J in Holland Vs Devitt and Moore Nautical College (1969) Times 4\textsuperscript{th} March.
\textsuperscript{354} (1955) SLR 200 (SC).
\textsuperscript{355} (1967)1 WLR 813.
and break down of the repair; c) that an operation was performed within four weeks; 
and d) that the hemorrhage occurred and the repair breakdown, the court applying 
these rule viewed prima facie departure was the breach of duty. The burden of 
showing that he was not in breach of duty shifted on the defendant\textsuperscript{356}. \textit{In Hepworth Vs Kerr}, the defendant-anesthetist invented new hypertensive anaesthetic technique which had not been adopted by any practitioner before. The technique was useful in providing a blood-free field for the operating surgeon. The defendant had experimented and used this technique previously on over 1500 patient, but at no point of time, he had attempted to make any proper scientific explanation as to its validity. It was completely outside the conventional method. It was held that without validation, the doctor could not justify in involving the patient in such a fundamental departure from conventional wisdom\textsuperscript{357}.

The criticism against the principle that a practitioner who departs from the accepted methods of treatment must provide some justification will have an inhibiting effect on doctors who tries to employ novel or experimental methods in the interest of their patients where the traditional techniques fail to achieve the suitable result.. In the interest of the community, medical profession should develop new and more effective methods of health care, without the fear that they may be sued for negligence on the pretext of deviation from the normal practice\textsuperscript{358}. However, utmost care is to be taken that the patients will not be recklessly subjected to untried and potentially dangerous experimentation\textsuperscript{359}.

3.4.2.5.3. Level of Literature knowledge:

It is concerned with knowledge and understanding of the medical literature. In this regard, some questions assume importance: is it the duty of the practitioner to know every new development that takes place in the medical profession? What is the extent to which a practitioner is expected to keep abreast of medical knowledge? These questions have drawn the attention of the courts in determining the standard of

\textsuperscript{356} (1983) 1 All ER 416.
\textsuperscript{357} (1995) 6 Med. LR 139.
\textsuperscript{358} Sidaway’s case, see 224.
\textsuperscript{359} Coughlin Vs Kunz (1987) 42 (CCLT) BCSC, the defendant was held to have been negligent for adopting a method of performing an operation which was experimental, unsupported by clinical study and favored by no other orthopaedic surgeon.
skill and care of the practitioner. Ordinarily, medical knowledge is not a static, rather it keeps changing from time to time, what was once considered as the correct procedure or method of treatment may no longer be treated as responsible. Hence, it is the obligation of the doctors to possess up to date knowledge of new developments in their respective fields. Once the risk involved in the traditional method is exposed, then an ordinary and reasonable competent practitioner is also expected to alter his practice accordingly, it would be negligent to continue using that procedure. However, the duty of the doctor to make honest reasonable effort to keep up to date, it does not mean, a doctor is expected to read every article or research paper published in the medical journal\textsuperscript{360}. If the doctor ignores the fact of risk, disclosed by the practitioner on several occasion, it will be negligent\textsuperscript{361}.

\textit{a) One must not look at 1947 accident with 1954 spectacles:} Lord Denning’s observation expressed in \textit{Roe Vs Minister of Health Authority}, shows that reasonable care or the duty to take reasonable care should be assessed in terms of the knowledge possessed by the profession at the time of accident and not in terms of the wisdom of hindsight. The subsequent development of medical knowledge cannot be taken into consideration to hold the professional negligent\textsuperscript{362}. Nonetheless, it will be incumbent upon a practitioner to keep abreast of advance in knowledge and technique within his area of expertise as they become disseminated through the medical journals. But the standard of care would not require him to be acquainted with every such article and reasonable time should be allowed for the dissemination and acceptance of knowledge and technique\textsuperscript{363}.

\textit{b) Knowledge of medicine goes beyond national boundaries:} In \textit{Rob and Unit Vs East London and City Health Authority}, the issue was whether a particular technique was negligent simply because the same thing performed differently in another place. The court pointed out that practices adopted in one country are not necessarily

\textsuperscript{360} Thompson Vs smith (1984)1 All ER 881, 894.
\textsuperscript{361} Mc Cornick Vs Marcottle (1071)20 DLR (3d) 345 (SCC); Mc Lean Vs Weir (1977)5 WWR 609.
\textsuperscript{362} (1987) QB 730; (1986)3 All ER 801.
\textsuperscript{363} See Dwan Vs Farquhar (1988)1 QB 234, where an article in journal concerning the risks of contracting the AIDS Virus from blood transfusion was published in March 1983, and a patient contracted HIV from a blood transfusion performed in May 1983, the doctor is not negligent for the reason that he did not immediately put into operation the suggestions given a contributor in the journal.
considered as appropriate evidence of standard in another, but the information regarding risks or hazardous involved in the particular treatment carried out somewhere else and the extent to which they could be reduced or avoided are highly relevant. A doctor needs to keep abreast medical knowledge based on the standard textbook as well as the latest individual articles, sometimes textbook may become outdated by the growth of knowledge between editions\(^\text{364}\). However, medical literature and the case law do not indicate any answer as to the time within which a doctor is expected to be familiar with new technique published in the literature.

### 3.4.2.2.5.4. Degrees of Risk.

Assessing the degree of risk in the treatment is another challenge posed by the issue of medical negligence. Whether the practitioner has exercised reasonable care, the courts take into consideration various factors such as the foreseeability of the damage, the magnitude of the risk, the purpose of the practitioner’s behaviour and the actual practicability of taking precautions. These aspects are highly relevant in evaluating the issue of medical negligence\(^\text{365}\).

a) **Foreseeability of Risk:** It is axiomatic within the area of the concept of negligence that if a particular danger is not reasonably able to anticipate, the defendant is not negligent, because a reasonable man cannot be expected to take precautions against the unforeseeable consequences. Whether the dangerous effect is foreseeable or not will be measured in terms of the knowledge as prevailed at the date of the alleged negligence\(^\text{366}\).

b) **Magnitude of Risk:** Generally, a practitioner is not negligent, if he does not take precautions against a foreseeable consequence. A reasonable doctor may foresee or anticipate possibility of many risks, but it is impracticable to state that he should take appropriate precautions against every risk which he can foresee rather, he has required to take precautions against risks which are reasonably likely to occur\(^\text{367}\). In

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\(^{364}\) Rob and Unitt Vs East London and City Health Authority (1999) MLC 102.

\(^{365}\) See Bolitho’s case wherein the House of Lords makes it clear that medical expert will have to demonstrate that they have addressed the question of assessing the relative risks and benefits of adopting particular medical practice.

\(^{366}\) Gold Vs Haringe Health Authority (1988) QB 481.

\(^{367}\) Bolton Vs Stone (1951) AC 850, 863.
determining the magnitude of the risk, medical evidence inter alia about the conduct of the practitioners should demonstrate that they have addressed the question of the relative risks and benefits of adopting a particular medical practice and their opinion based upon logical analysis. It should be noted that there is clear relationship between the magnitude of the risk and the duty of care, in particular the standard of care. The greater the risks involved in any proposed course of treatment, the more carefully and anxiously must the medical practitioner weigh and consider the possible alternatives before deciding to resort to the proposed treatment\textsuperscript{368}.

If the harm is likely to be serious, does occur, then greater precaution must be taken, for instance, a risk that a patient may be accidentally infected with HIV from a contaminated blood transfusion will impose a high standard of care upon the supplier of the blood considering the seriousness of the consequence\textsuperscript{369}. In \textit{Whiteford Vs Hunter}, the defendant did not perform a biopsy to confirm his diagnosis of prostate cancer, since he considered there was a risk of performing the bladder wall, and unhealing ulcer likely to happen. The court cited two elements involving in the magnitude of the risk, such as the likelihood that the harm will occur and the severity of the potential consequences\textsuperscript{370}.

\textbf{3.4.2.2.5.5. Specialists:}

The issue to be discussed is the standards of care of the specialist, whether a specialist is expected to act as ordinary skill of competent doctor. It is argued that a specialist requires to exercise the standard of care of a reasonably competent specialist in the field concerned. He must exercise the ordinary skill of his speciality\textsuperscript{371}. As recognised in \textit{Sidaway’s} case a general practitioner will be judged by the standards of general practitioners and not specialist\textsuperscript{372}, if a general practitioner undertakes the task of the specialist, even though not competent, he will be judged by the standards of that specialty. In case, he is unable to possess those standards, then he will be held

\textsuperscript{368} Battersby Vs Tottman (1985) 37 SARS 542
\textsuperscript{369} E Vs Australian Red Cross Society (1991) 105 ALR 53, 77 (Aus. Fed. AC), per Sheppard J.
\textsuperscript{370} (1950) WN 553.
\textsuperscript{371} Maynard Vs West Midlands Regional Health Authority (1984) 1 WLR 634.
breach of duty owed to his patient. Thus one should not undertake the task beyond his competence.

The standard of care within a specialist field is that of the ordinary competent specialist, not the most experienced or most highly qualified within the area of specialty. This appears that a specialist must take greater precautions than an average doctor when undertaking the same task. On the other hand, he does not have to use a higher degree of skill than comparable specialists.

3.4.2.5.6. Inexperienced practitioner:

It is axiomatic that the standard of care expected of the reasonable man is objective and not subjective. Because objective standard eradicates the personal equations and it does not take into account the particular idiosyncrasies or weakness of the practitioner. A practitioner who has no experience or who has been learning in the particular field or skill is also required to achieve the standards of the reasonably competent and experienced person. His inexperience and incompetence is not just excuse. An inexperienced doctor will be dealt with in the same way of an experienced and competent. As required by Bolam test, a doctor must reach the standard of a competent and experienced doctor. In Jones Vs Manchester Corporation, a patient died due to excessive dose of anaesthetic administered by a doctor who had been qualified for 5 months. In a suit for negligence, it was held that it was no defence to state that he did not have sufficient time to undertake the task or to say that the surgeon in charge was also to blame. It is the patient right to receive all the due care and skill which a fully qualified and well experienced anaesthetist would possess and use.

In Wilsher Vs Essex Area Health Authority, a premature baby received excessive oxygen due to an error in monitoring its supply of oxygen. An inexperienced doctor had inserted a catheter into a vein rather than artery. The baby was found to be suffering from retrolental fibroplasia which causes blindness.

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373 Giuelli Vs Girgis (1980)24 SAR 264, 277 per White J; F Vs R (1983)33 SASR 189, 205 PER Bolten
375 Nettleship Vs Weston (1971)2 QB 691, 710.
376 (1952) QB 852.
possibly as a result of the exposure to excess oxygen. There was a difference of opinion on the question of the appropriate standards of care to be applied to the junior doctor. The court said that an inexperienced doctor should not have undertaken the treatment, but referred the patient to someone possessing the necessary skills. The standard of care could not be measured by reference to the inexperienced doctors. The objective standard of care should not be related to the individual, but to the post which he occupies, as the post is different from the rank or status. The judicial approach makes it clear that except emergency, the unqualified or inexperienced who undertakes treatment which is beyond his competence will be required to possess reasonably competence of an experienced practitioner. If he is unable to exercise objectively required standard for any reason, be it stress, overwork, tiredness or ill health, he will be found negligent.

3.4.2.2.5.7. Hospital Authorities:

If the health authority allows inexperienced staff to treat patients without adequate supervision, it will be breach of primary duty of care to the patient. In \textit{Jone’s} case the court held the hospital liable for inexperienced doctor whose negligence caused the patient’s death. It would be highest degree of unjust by employing inexperienced doctors to perform their duties to the patients without proper supervision. However, there is a difficulty with measuring standard of care applicable to the hospital authority where it fails to employ sufficient numbers of staff or staff with sufficient experience. Nonetheless the health authority will be vicariously liable and therefore financially responsible for a doctor’s culpable errors.

3.4.2.2.5.8. Alternative Medical Practice:

Another issue concerning negligence would be what should the standard of care of one who practices a different type of medicine from the normal type? Is it

\begin{itemize}
\item[(1986)] 3 All ER 801.
\item[(1999)] 1 WLR 1263.
\item[1963) 41 DLR (2d) 697 where the hospital has been held negligent for failure to give instruction to and supervision of junior doctor in the use fo a new method of inserting an intravenous catheter.
\item[2000)2 I.R Supreme Court of Ireland, opined that any system of the hospital which gives absolute authority to a junior doctor is inadvisable.
\end{itemize}
sufficient to judge them by the standard of the competent practitioner of that of medicine? It is argued that in the case of practitioners of “alternative medicine”, they should be judged by reference to the standards of fellow practitioners, not by the standards of conventional medicine\(^{381}\). A practitioner of homeopathic or herbal medicine must conform to the standards of a reasonably competent practitioner of that art. He does not require to comply with the standards of orthodox medicine. In *Shakoor Vs Situ*, the defendant who was a properly trained, well-qualified and experienced practitioner of Chinese herbal medicine consulted by the patient with skill problem for which the only orthodox medicine was surgery. The defendant prescribed an herbal remedy, some days later the patient suffered liver damage and died. The evidence showed that the remedy had produced a rare reaction which could not be predicted. The plaintiff contended that papers published in orthodox medical journals suggested that administering such herbal remedy gave rise to a risk of liver damage. The defendant did not read orthodox medical journals, but believed that remedy would be completely safe in the Chinese medical text books. The court held that the defendant should not be judged by the standards of orthodox medicine since he did not hold himself out as practicing orthodox medicine\(^{382}\).

### 3.4.2.5.9. Misdiagnosis:

Diagnosis is the basis of clinical judgment, as it serves two purposes namely, determine the need of treatment and choose the appropriate mode of treatment. A doctor is expected to exercise a reasonable degree of care in making diagnosis his patients. Where the standard of care is observed, a mistake in diagnosis will not be negligent but it will be treated as one of the non-culpable and inevitable hazards of practice\(^{383}\). Error in diagnosis may be held negligent when the practitioner fails to act as a reasonably competent doctor in the circumstances of the case, for instances failure to take proper medical history\(^{384}\), failure to diagnose the condition which

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\(^{381}\) Supra n 89 p 250.

\(^{382}\) (2000)1 WLR 400.

\(^{383}\) Crivon Vs Barnett Group Hospital Management (1959) Times , 19 November, the court observed on misdiagnosis: ‘unfortunate as there was wrong diagnosis, but it was one of those midadventures, one of those chances, that life holds for people’.

\(^{384}\) Chin Keow Vs Government of Malasia (1967)1 WLR 823 where there was failure to inquire as to the possibly of pencillin allergy; Coles Vs District Hospital Management Committee (1963)107 Sol Jo 115 where the defendant failed to consider possibility of tetanus.
would have been spotted by a competent practitioner\(^{385}\). A want of reasonable care is to be established as necessary to find the doctor negligent for diagnosis. In *Furstenau Vs Tomlinson*, the plaintiff was suffering from a skin infection Dr. Tomlinson diagnosed it as eczema, inspite of remedy the plaintiff’s condition got worse and he finally sought second opinion. The doctor whom he then consulted diagnosed scabies. The plaintiff sued the defendant for negligence and ignorance. It was observed that mistake alone on the part of the doctor was not sufficient to enable the plaintiff to sue; he needed to establish a want of reasonable amount of skill. The original mischief was eczema and subsequent was scabies which was masked by the eczema that it was impossible to diagnose it at that time\(^{386}\).

3.4.2.2.6. STANDARD OF CARE: Specific Instances

It is possible in the realm of the diagnosis and treatment; exercise the duty of care in careless manner, or omitting to do something which ought to be done to save life of the patient. Here, the thesis attempts to discuss some form of negligence which may arise in the course of treatment and diagnosis. Admittedly, it must be borne in mind that these specific instances of negligence have been measured in terms of the test laid down in Bolam case. Sometimes there is aberration, but it does not mean the Bolam test is no longer in existence or abrogated. Till today the Bolam is valid, inspite of there has been criticism. The following instances reflect the generic form of negligence.

3.4.2.2.6.1. Failure to Attend or Treat:

One of the important duties of the doctor is to attend his patient with due care and caution; he will be negligent if he fails to attend, upon the proof that his attendance was so essential in the best interest of his patient. In deciding whether the failure to attend or treat would constitute negligence, various factors are to be taken such as patient’s physical condition, conduct, the doctor undertaking, and his commitment to other patients at the same time. In *Barnes Vs Crabtree*, the plaintiff brought action against the defendant for failing to treat her, although the defendant on examination stated that there was no illness, and if she was not satisfied, she could


\(^{386}\) (1902)2 BMJ 496.
also consult another physician. The court held that the doctor’s obligation was to render all proper and necessary treatment to the patient; this did not mean that he was bound to make full clinical examination each time the plaintiff asked for it\(^{387}\).

A. **Emergency Service:** In Barnett’s case, the casualty officer refused to treat three persons who were vomiting after having some tea at night duty, by a reason that he himself was vomiting. The court condemned his behaviour by stating that he should have seen and examined the patient, the failure to do so, the casualty officer was negligent\(^{388}\). Where there is casualty department in the hospital meaning for the public good impliedly undertakes to serve the public with the professional skill and knowledge, it will be liable for negligently failing to provide emergency service\(^{389}\).

B. **Arranging appointment in future:** In Lowe Vs Havering Hospitals NHTS Trust, where the patient who had dangerously high and unstable blood pressure, was advised by the doctor to take appointment eight weeks later. As result of delay in arranging appointment for treatment, patient suffered stroke, which could probably have been avoided if the medication had been rendered. The doctor was held negligent for failure to attend the patient even though the situation warranted the care of the doctor\(^{390}\). However, the doctor is not liable if he fails to undertake the treatment on account of his commitment to other patients\(^{391}\).

C. **Post operative treatment:** The duty to attend or treat extends to post-operative treatment. In Corder Vs Banks, the surgeon after performing the operation on the plaintiff’s eye lid discharged him from the hospital without making any arrangement as to provide service in the event of bleeding during the first two days after the operation. The surgeon was found to have been negligent. Only the limitation of this duty would be that it cannot be extended to supervise routine procedure or treatment of the patient\(^{392}\).

\(^{387}\) (1955) Times 1-2 November.
\(^{388}\) Barnett Vs Chelsea Kensington Hospital Management Committee see n 279.
\(^{389}\) Fraser Vs Vancouver General Hospital (1951)3 WWR 337 (BCC); affirmed (1952)3 DLR 785 SCC.
\(^{390}\) NHTS Trust (2001) 62 (BMLR)
\(^{391}\) Smith Vs Rae (1919)51 DLR 323.
\(^{392}\) Morris Vs Winsbury-White (1937/4 All ER 494.
3.4.2.6.2. Errors in diagnosis:

A. Failure to take a full medical history: Error in diagnosis and treatment occurs for various reasons, such as failure in taking medical history, in examining the patient; in analysing the patient’s symptoms; failure to conduct proper pathological tests etc., Before embarking upon the treatment, it is necessary to take full and complete medical history of the patient, and failure to do so, results in serious consequence. The classical example is Hollingsworth Vs Dartford and Gravesham Health Authority, where prior to conduct caesarean section operation under general anaesthetic, the anaesthetist did not take require pre-operative history which would have revealed a history of allergic and asthma. The petitioner became ill due to allergic reaction to the drug, yet, the anaesthetist administered further dose without taking history of allergic reaction. As a result of which, the petitioner developed a serious illness. It should be noted that had the complete history been taken, further deterioration of illness could have been avoided. Taking medical history of the patient does not confine to see only the signs and symptoms of the illness for which the patient seeks the medical treatment or therapy, it also includes making enquiry about the previous treatment taken for the same condition or previous injury. Similarly, the duty to listen to the patient is also essential component of taking history of the patient. Unless the patient being heard with due care, it will be difficult to trace the diagnosis. In a situation where the doctor fails to hear his patient who as a result suffers it constitutes negligent. At the same time, the patient is also equally responsible to furnish true and frank information when it required by the doctor. If the information given by the patient is false or vague, the doctor cannot be held responsible for acting upon it.

B. Failure in Diagnosis: The issue of whether the error of clinical judgment constitutes breach of duty is very difficult task. It has been argued that mistaken diagnosis is not necessarily a negligent, because in reality, human being is fallible as such, in the present state of science even the most eminent specialist may fail in detecting the true nature of the deceased condition. A practitioner can be liable in this

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395 Wilsh Vs North East Essex Area Health Authority (The times, February 21, 1987; (1988)1 All ER 871.
396 Followed by Lord Denning comment: “a professional man, an error of judgment is not negligent” in Whitehouse Vs Jordon (1981)1 All ER 267 (HL).
respect if his diagnosis is so palpably wrong, that is to say, if his mistake is of such nature as to imply absence of reasonable degree of skill and care on his part. In *Whitehouse Vs Jordon*, the House of Lords observed that: “merely describing something as an error of judgment does not indicate anything about whether it is negligent or not. The true position is error of judgment may or may not be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have that standard and type of skill that the defendant held himself out as having and acting with ordinary care, then it is negligence. If on the other hand, it is an error that a man, acting with ordinary care might have made, then this error of judgment is not negligent”.

The failure of diagnosis will be negligent, if the doctor does not shows reasonable competency or falls below the standard of a reasonably skilful medical man. In *wood Vs Thurson*, a drunk man was brought to the casualty ward of a hospital with a history of having been run over by a motor lorry, with 18 broken ribs, a fractured collar bone and badly congested lung. The surgeon neither did examine as closely as required nor used his stethoscope to discover the patient’s true condition. Added to that he permitted the patient to return home where after a few hours died. The surgeon was found negligent in failing to make proper diagnosis.

In *Payne Vs St. Helier Group Hospital Management Committee*, the patient was kicked in the abdomen by a horse. The surgeon saw a bruise but concluded that there was no internal injury. The patient was allowed to go home and subsequently he developed a fatal degree of peritonitis. It was held that the doctor should have re-checked his own diagnosis after further observation or should have obtained a second opinion. The failure to rediagnose properly following changes and developments in the patient’s signs and symptoms is negligence. However, in certain cases where the failure in diagnosis occurs due to difficulty of making diagnosis, it will not necessarily be termed as negligence, for example, a pathologist diagnoses cancer where it transpires that the growth being in fact non-malignant, such error happens sometimes even if it

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399 (1951) Times, 25 May.
400 (1952) Times 12 November.
is diagnosed by the greatest expert in the field, of course it is a wrong diagnosis but it is not necessarily a negligent diagnosis\textsuperscript{401}.

C. \textit{Symptoms observation}: The success and failure of diagnosis depends upon the observation of symptoms. Where symptoms do not indicate the illness of the patient who is in fact suffering, the doctor cannot be blamed for failing to identify the specific ailment. In the absence of symptoms of disease, it becomes very difficult to make observation even though the patient suffers from something serious which needs high diligence to trace\textsuperscript{402}. Under these circumstances, the doctor has to take additional precautions like admitting the patient for further examination or conducting further pathological tests, failure to do so the doctor may be held liable. In \textit{Bova Vs Spring} the practitioner diagnosed a muscle strain in the patient’s chest, but the patient died two days later from pneumonia. The defendant was held to have been negligent in ‘failing to recognise uncertainties attending his diagnosis’\textsuperscript{403}.

D. \textit{Use of diagnostic aids}: It is an integral part of the duty of the physician. It will be negligence, if he does not use the available diagnostic aids or equipments in the hospital. In \textit{Hutton Vs East Dyfed Health Authority}, the plaintiff with the complaint of chest pain consulted the defendant hospital, where the doctor who examined him did not conduct chest X-ray on the wrong conclusion that the patient being a pregnant woman, taking X-ray would involve danger to foetus. The court rejecting his contention held him negligent for not using the equipment\textsuperscript{404}.

E. \textit{Duty to identify serious condition}: Generally, a doctor cannot be held responsible, if he fails to diagnose provided that he acted with reasonable skill and care. Where the condition of the patient is so serious, if the doctor fails to spot it through his diagnostic technique, then, the question arises: can he be held negligent? What is the duty of doctor where he fails to discover the seriousness of the disease or illness? In \textit{Dale Vs Munthali}, the patient was suffering from meningitis whereas the doctor diagnosed the patient as suffering from influenza. Did the defendant breach his duty

\textsuperscript{401} (1959) Times, 19 November.
\textsuperscript{402} Supra n 318.
\textsuperscript{403} (1994)5 Med. LR 120, QBD.
\textsuperscript{404} (1998) Lloyd’s rep 335 at 345 QBD.
to identify proper illness? The court viewed that the defendant-doctor should have realised it was more than influenza when the patient was extremely ill and thorough examination should have been done or patient should have been referred for further tests. The doctor himself gives rise an occasion to make the charge of negligence where he does not exercise certain standard of care, or acts beyond his experience or speciality or fails to seek expert’s opinion as the case required.

F. Duty to keep the diagnosis under review: Breach of duty occurs where the doctor fails to review the diagnosis as the treatment progresses, or as the patient’s condition does not respond to diagnosis or treatment, or consults or refers the patient to the expert. This fact has been considered by the Canadian court in *Layden Vs Cope* wherein a patient with a history of gout called on two specialists who diagnosed him of gout and administered medication accordingly. Inspite of this, there was no improvement, rather, the condition deteriorated. Finally, the patient was taken to another specialist who diagnosed him as suffering from staphylococcal infection, as the infection so serious, the patient’s leg had to be amputated below the knee. The instant case shows that the failure on the part of the practitioners to revise their diagnosis or treatment although the patient had been hospitalised for a longer period and their failure to explore alternative diagnoses.

*In Bergeon Vs Sturgeon General Hospital*, the tentative diagnosis reveals the patient suffering from acute gastroenteritis and appendicitis, after initial improvement the condition of woman deteriorates, but the surgeon fails to notice sign of improvement and take further remedial measures to rule out appendicitis. The patient dies due to a ruptured appendix, following an emergency operation. The defendant surgeon not only committed wrong diagnosis but also neglect to notice the patient’s condition after administering the treatment. The observed that: “an ordinary common sense dictates that when a person is dealing with life-threatening malady that has been brought to the attention of the practitioner, it would be the responsibility of the practitioner to take precautions in view of signs, symptoms and informations.”

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405 (1976) 78 DLR (3d) 588.
G. Duty to arrange tests for diagnosis or treatment: It poses a question whether a reasonable doctor goes for X-ray or any other test before treating his patient. It is suggested that where diagnostic aids are available, the doctor should use them, however this is not mandatory procedure as it is matter of clinical judgment\textsuperscript{408}. In \textit{K.N. Lal Vs R.K. Akhaury} wherein the doctor who has diagnosed the ailment as muscular oedema for diminishing vision of the patient advised change of glasses. After just three months the patient had the same problem. When he consulted the defendant-doctor who diagnosed the ailment as nuclear cataract, suggested change of another glass and undergo cataract operation. The defendant explained about the nature of operation as conventional type, there was no cause for any anxiety. On removal of the bandage, the patient had no vision in his right eye. The perusal of evidence showed that IOP test (Intra-ocular pressure) was essential before taking up operation. This was the serious omission on the part of the doctor. This omission of conducting essential test before the operation is held negligence in breach of duty to exercise reasonable care in carrying out his professional skill of diagnosis, advice surgery and treatment\textsuperscript{409}.

H. Duty to consult or refer to specialist: Where a physician comes to know that the diagnosis or treatment is beyond his capacity, or involves very complication, it is his duty to summon another physician who has the necessary ability or refer the patient to a specialist\textsuperscript{410}. If he fails to do so by attempting to diagnose himself or undertaking the task beyond his competence, he will be negligent if the harm causes\textsuperscript{411}. For instance, if a doctor suspects cancer, he should immediately refer the patient to a specialist or arrange for an immediate biopsy, a failure to do so constitutes negligence\textsuperscript{412}. Similarly, a consultant in expertisation who has not come across the difficult problems in treatment will have the obligation to refer to a specialist or seek

\textsuperscript{408} Lackey Vs Merton, Sutton and Wandsworth Health Authority (1999) 48 BMLR 18 (CA)

\textsuperscript{409} (1997)3 CPR 398; in Hallat Vs North West Anglia Health Authority (1998) Lloyd’s Rep. Med. 197, CA it was held that it is matter of clinical judgment involving a number of factors, for eg., the general practitioner who failed to screen a pregnant woman for gestational diabetes was negligent; in Pierre Vs Marshall (1994)8 WWR 478 (Alta. QB) where an obstetrician who failed to test a patient for syphilis (commonly transmitted by sexual intercourse) during her pregnancy was negligent. On the other hand, in X and Y Vs Pal (1991)23 NSWLR 26; (1992)3 Med. LR 195 (NSWCA), the court held that a doctor should not be blamed for negligence for refusal to offer a CT scan or any other diagnostic procedure, which he considered inappropriate.

\textsuperscript{410} See International Code of Medical Ethics: Duties of physician to sick.

\textsuperscript{411} Moses Vs North West Herefordshire Health Authority 1987, CA ; (unreported) cited in Michael A Jones n 318 p 302.

\textsuperscript{412} Wilson Vs Vancouver Hockey Club 91983)5 DLR (4th) 282 at 288.
the advice from the specialist concerned\textsuperscript{413}, and where a doctor who fails to interpret a cytology report correctly, owes an obligation to seek clarification of the report and advice for further investigation\textsuperscript{414}. In \textit{Poole Vs Morgan}, wherein the ophthalmologist who did not have training as to the use of laser, performed retina vitreous which was normally done by the specialist. It was found that since he was not possessed expert skill, it was his duty refers the patient to such a specialist\textsuperscript{415}.

3.4.2.6.3. Failure of Advice and Communication: This failure arises where there has been no or improper consultation or discussion between the practitioner and his patient regarding the possible diagnoses, course and prognosis of the disease, options of treatment available, side effects of the treatment, chances of success etc., The want of required communication results in a breakdown of the doctor-patient relationship and the patient may feel that only way to ascertain the procedure of treatment by the practitioner will be approaching the court of law. It is the right of the patient to know the diagnosis, prognosis, inherent risk of the treatment, availability of alternative procedure. Hence, the corresponding duty of the practitioner is to understand the nature of treatment and have communication with the patients. However, this task poses difficulty in determining how much information of a patient should receive, whether the doctor has any discretion to withhold or distort information and whether the standard of care in communicating information should be different in therapeutic and non-therapeutic cases.

A. \textit{Duty to inform about risks}: The doctor must disclose to the patient about the medical condition and the method of treatment and risk of treatment in order to enable the patient to decide whether to accept or refuse the treatment. It is not only the doctor’s duty of care to warn about the inherent risk of the treatment, it is also duty to inform the patient what has gone wrong in the provision of treatment\textsuperscript{416}. Until 1950s the disclosure of information had been considered as a matter within the discretion of the doctor’s professional judgment\textsuperscript{417}. In \textit{Sidaway’s case} the court pointed out that it

\textsuperscript{413} Gascoine Vs Ian Sheridan (1994)5 Med. LR 437, at 447 where a consultant gynagologist was encountered with an unexpected problem of an invasive carcinoma\textsuperscript{5} following the operation of a simple hysterectomy.

\textsuperscript{414} Taylor Vs West Kent Health Authority (1997)8 Med.LR 251.

\textsuperscript{415} (1987)3 WWR 217.


\textsuperscript{417} Daniel Vs Heskin, (1954) IR 73 Supreme Court.
was the duty of doctor to answer the patient’s questions about the proposed treatment. This approach reflects that the practitioner is no longer enjoying the medical paternalism which has been practiced by the doctor since the time of Hippocratic Oath. In *Stamos Vs Davis*, in the course of undertaking biopsy the petitioner’s spleen got punctured, but the defendant answered in casual way that he didn’t get what he wanted, thus withheld the information regarding ruptured spleen. A few days later again the patient admitted in the hospital where the spleen was removed surgically. It was held that the defendant was a under a duty to inform the patient that spleen had been punctured, this failure was a breach of duty 418.

B. *Duty to give instructions*: It is not the simple case of giving instructions, the health carer in doing so should exercise special care to ensure that the patient has understood the instructions as well as importance of following up of them. This obligation encompasses various subjects like advice about the treatment; risk involved therein, lifestyle of the patient, side-effects of the treatment and diet. A failure on the part of health carer to provide instruction regarding potential danger involved in the treatment will be negligence. In the case of *Clark Vs Adams* the plaintiff was treated by the defendant - physiotherapist for a fibrocystic condition of his left heel. The defendant before applying treatment states: “when I turn on the machine I want you to experience comfortable warmth and nothing more; if you do, I want you to tell me”. As consequence of the treatment, the plaintiff suffered injury by burning which eventually led to the amputation of left leg below the knee. The court found that the warning given was inadequate to enable the plaintiff to be safe. The safety of the plaintiff depends upon the proper instructions of the practitioner 419. Thus the court has recognised the competent patient’s right to understand his treatment as inalienable right in terms of the medical care.

C. *Duty to inform other health professionals*: Any communication gap between the treating practitioner and other professionals that results in dangerous consequences for the patient will be termed as ‘organisational failure’. It is the breach of duty of care

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418 (1986)21 DLR (4th) (Ont.HC); However, the General Medical Council now, has issued some guidelines to doctors in connection with giving information to patient/relatives when something goes wrong with the treatment. See GMC Good Medical Practice, May 2001. In India Medical Council has not made such an attempt to enlighten professionals with the patients right to know the effect of the treatment.

where the hospital does not have the provision for summoning specialist assistance when it is needed\textsuperscript{420}. Lack of co-ordination between doctors, and hospital authority and doctors and nurses constitute negligence\textsuperscript{421}.

### 3.4.2.6.4. Substandard Treatment:

Majority of malpractice litigation concerns to substandard treatment involves error in treatment, retaining foreign object in the site of the operation, wrong operation, and anaesthetic mishaps so on.

#### A. Error of Treatment:

The error in treatment arises on account various reasons such as the practitioner’s lack of knowledge\textsuperscript{422}; want of adequate skill in exercising a particular method\textsuperscript{423}; inadvertent or accidental slip\textsuperscript{424}; or departure from the standard procedure approved by the medical body\textsuperscript{425}. However, all cases of error or mistake in treatment does not constitute negligence. As the Bolam test indicates only the error which would not have been committed by reasonably competent doctor exercising ordinary care that amounts to negligence. The aggrieved must prove that it was unreasonable error. Therefore, to describe an error as an “error of professional judgment” in deciding the issue of negligence, it must be shown that the doctor has fallen below the proper standard. On the other hand, if the practitioner proves that he was acting within or in accordance with the mode of practice accepted as proper by responsible body of practitioners and that he was using requisite degree of skill and care during the administering of the treatment, he would not be negligence of mistake that occurred.

In \textit{A. Xavier Vs Cantonment Policlinic and others}, a person who had slight temperature, body pain due to regular work and strain admitted in the defendant hospital, during the treatment some complications developed for which the defendant conducted surgery for the removal of gall bladder. The condition did not improve;

\textsuperscript{420} Bull Vs Devon Area Health Authority (1989), (1993)4 Med. LR where Slade LJ described the system of summoning expert obstetric assistance as “operating on a knife edge”.

\textsuperscript{421} Holmes Vs Board of Hospital Trusts of the City of London (1977) DLR (3d) 67, 94. (Ont. HC).

\textsuperscript{422} Reynard Vs Carr, (1980)30 CCLT 42 (BCSC).

\textsuperscript{423} Jones Vs Manchester Corporation (1952) QB 852.

\textsuperscript{424} Gonda Vs Kerbel (1982) 24 CCLT 222.

\textsuperscript{425} Clark Vs McLennan (1983) All ER 416.
rather there was heavy bleeding from the site of operation. The defendant performed second operation de to which the patient was ultimately shifted another hospital where the patient died. The report disclosed that the patient’s ball bladder had been removed carelessly and negligently as a result of which kidney had been damaged while performing the earlier operation. The death happened due to gross dereliction of duty, negligence and did not possess reasonable degree of care and skill while treating the patient426. Where the practitioner shows lack attention and alertness which fall short of the standard of care which reasonably expected in the circumstances leads to draw inference of negligence. However, a doctor is not guilty of negligence simply because something went wrong in the course of surgical treatment. In Whitehouse Vs Jordon, the doctor is alleged to have pulled out the child in the course of a forceps delivery and alleged negligence in failing to do caesarean section delivery. The court rejected the allegation by holding that the defendant was not negligent. In the court’s opinion every mistake or error during the course of an operation or treatment does not constitute negligence. On the other hand, the doctor could be held guilty for attempting to deliver a child by forceps when it was too far in the mother’s pelvis and for failing to undertake a caesarean section delivery427.

B. Needles and Injections: There are number malpractice litigations where the plaintiff alleges that an injection is administered in the wrong place or contains the wrong substance or the needle breaks in the medical treatment, the point is whether such errors give rise the cause of action for medical malpractice. It is argued that mere breaking of the needle of a hypodermic syringe is not indicative of negligence. In order to determine this question the court must seek sufficient explanation as to why such mishap has occurred. In Brazier Vs Ministry of Defence, the plaintiff who was clearing up wrecks in the Sue canal contracted by infection. The doctor while giving injection of procaine pencillin, about one and a half inch needle broke which remained lodged in the plaintiff’s site. The plaintiff contended that the defendant held syringe as if it were a dagger and plunged the needle from a distance of 10 to 12 inches and there he failed to take proper care. Whereas the defendant explained that

426 I (2005) CPJ 229; in Winterbone Vs West Suffolk Health Authority, (1994)1 CL 135, where the stitching of the bladder to the vaginal vault resulting in a fistula was found to have been caused by negligence.
427 (1981)1 All Er 267; in Parry Vs North West Surrey Health Authority (1994)5 Med. LR 259; see also Bowers Vs Harrow Health Authority (1993)6 Med. LR16; De Martell Vs Merton and Sutton Health Authority (1995)6 Med.LR 234 where the doctor was held to have been negligent in pulling too hard with a ventouse, causing traumatic injuries to the child’s brain.
there no stabbing by him with syringe rather, he held it in a closed fist and inserted the needle in accordance with recognised manner. The court held that the latent defect in the shaft of the needle caused the breaking. The ruling represents that mere breaking of needle in administering it is not necessarily negligence, but if the practitioner fails to cope up or tackle the consequence of it then, it give rise the inference of negligence. In a Scottish case of Henderson Vs Henderson, the surgeon performs an operation on the patient for the removal of her tonsils. At the end of the operation, severe bleeding occurs, the surgeon in his attempt to control bleeding by stitching, a needle breaks and two-third of it remained in the patient’s throat. The defendant tries to trace the fragment needle with his finger and with a scalpel; this search lasted unsuccessfully for an hour. The missing part of needle was removed at another hospital by an electromagnet. The prolonging probe and stretching of fibres will have serious and permanent consequence. The court observed that had the defendant exercised the care and skill reasonably expected of a surgeon, after a few minutes he would have desisted from his blind search. Thus, persisting with search constitutes negligence.

C. Misjudging treatment reactions: Medical practitioners and drug manufacturers equally contribute in the filed of healing practice. While the former administer drugs, and latter manufacture drugs. Failure either on the part of the practitioners or manufacturers resulting in injury to the patient, ends the matter with litigation. Therefore, medical practitioners and manufacturers need to exercise utmost care and diligence in the discharge of their obligations to the patients. In a situation where a doctor disregards the manufacturer’s guidelines and warnings, raises a series of question whom should be held liable? Is the doctor who prescribes medicine bound to follow the instructions? Can a doctor be blamed for adverse reaction of drugs? Does the manufacturer owe duty of care to the patient? It has been observed that the practitioners may take into consideration manufacturer’s instructions and known side effects of drugs although they are not necessarily bound by the manufacturer’s instructions since prescribing drug is the clinical judgment. If the doctor does not

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429 (1955)1 BMJ 672 SCS.
430 Buchan Vs Orthopharmaceuticals Limited (1986)25 DLR (4th) 658 (Ont.CA)
follow the manufacturer’s guidelines, he cannot be imputed as negligence\textsuperscript{431}. Similarly, a manufacturer cannot be held negligence because warning instructed in the drugs virtually amounts to performance of the duty of care to the patient. If the doctor prescribes high dosage or beyond the recommended dosage by the manufacturer, it is the responsibility of the doctor who has to justify his action as proper.

In \textit{Battersby Vs Tottman}, a doctor prescribed a very high dose of melleril to a patient who was suffering from a mental illness. He was aware of the fact that drug likely to cause severe consequence of permanent eye-damage. Yet he proceeded with the drug under the impression that the benefit of drug could withstand the risk of the side effect. Patient sustained permanent eye-damage. The decision of the doctor in prescribing high dosage in contravention of the instruction was held not negligent on the ground that risk was severe if the instruction had been followed\textsuperscript{432}.

D. \textit{Causing or failing to prevent infection}: Another obligation of the health carer is to protect the patient from infection during his stay in the hospital. A patient should not be discharged from hospital in an infectious condition or infects someone with whom he comes into contact\textsuperscript{433}. Hospital owes duty of care directly to a patient irrespective of vicarious liability\textsuperscript{434}. In \textit{Heafield Vs Crane}, after the birth of a child, the petitioner was shifted from the maternity ward to a general ward where a patient was suffering from puerperal fever, the petitioner caught to the infection from this patient. It was held that hospital was negligent in shifting the patient to the ward where there was gravely suspicious case of infection and in failing to warn the patient and isolate the infectious patient from the others\textsuperscript{435}. However in case of post operative infection, the infection will not be treated as evidence of negligence as the health carer cannot guarantee that post operative infection would not occur\textsuperscript{436}.

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\textsuperscript{431} Vernon Vs Bloomsbury Health Authority (1985), (1995)6 Med LR. IR 297. \\
\textsuperscript{432} (1985) 37 SASR 524 (S.C of Australia). \\
\textsuperscript{433} (1906)1 KB 160. \\
\textsuperscript{434} Cassidy Vs Ministry of Health (195101 All ER 574. \\
\textsuperscript{435} The Times July 31, 1937. \\
\textsuperscript{436} Hajgate Vs London Health Association (1982) 36 OR (2d) 669, 681 (Ont.HC). 
\end{flushright}
E. **Nurses:** As it has been seen in the foregoing discussion, the medical practitioners and hospital authorities could be held negligent if they failed to exercise reasonable degree of care and skill in attending patients. As regards nurses, a question arises: whether the nurses are under a duty to exercise reasonable degree of care and skill in the tasks they undertake. Historically, nurses were treated to be independent contractors and the employing hospital was not automatically vicariously liable for their torts. However, today the employing hospital authorities are vicariously liable for the done by the nurses in breach of their duty of care. Now-a-days, nurses also come across with the allegation of substandard treatment and want of due care, in *Walker Vs South West District Health Authority*, where, the nurse administers injection into the right thigh of the patient contrary to all good practice. As consequence of this, injection damaged superficial nerve, causing the patient numbness in the right leg. The court finds that no careful nurse or doctor would administer injection there in the absence of some compelling reasons. It is clearly negligent of the defendant.

One of the important duties of the nurses is to count the retained products after the operation. If the retained surgical products are left in a patient following an operation constitutes breach of duty of the nurse. This duty is to be perfomed in the interest of the health carer as well as the patient. Likewise, a nurse should not undertake the case which she knows to be beyond her power. In *Lalitha Vs Jeeva*, where the nurse who has undertaken the management of a situation of pregnant with a dire consequence for second caesaren operation, ultimately led to the removal of uterus and the death of child. The defendant-nurse was found to have acted rashly, recklessly and with culpable negligence.

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438 Fussel Vs Beddard (1942)2 BMJ 411, the hospital held negligent for the death of a patient due to wrong injection given by the nurse.
440 Mahon Vs Osborne (1939)2 KB 14; Urry Vs Bierer and Another, Times, 15 July.
441 (1992)2 CPR 409 (TNSCDRC).
3.4.2.3. CONSEQUENTIAL DAMAGE: Reasonable foresight

In addition to the issue of existence of ‘duty’ of care and the ‘breach’ of standards of skill and care, the conception of medical negligence consist of another important element of ‘damage’ as a result of such breach of the standards. A person, who alleges that the doctor was negligent, must establish loss or injury sustained by him as a result of or consequence of breach of duty. Beside this, in order to succeed in medical malpractice litigation the ‘causative link’ has to be established between the act of negligence and the injury caused. The issue of damage is subject to three conditions:

A. The damage must be caused by the breach of duty: A person alleging negligence on the part of the practitioner is required to establish the causative link between the negligent act and consequential damage. In *Bernett’s case*[^442] the court refused to hold that the casualty officer was liable for the death of a patient on account of lack the element of causation for the death. Thus, it is not sufficient to argue that negligence occurred, but the cause of death should be linked to the act of the doctor. The test to determine the proximate cause to the damage is to establish that if the patient had received due care, he would have not died. In *Robinson Vs Post Office*, the defendant did not administer test dose before injecting into a patient who developed some complication leading to brain damage and paralysis. The court dismissed the charge of allegation on the basis of evidence which showed that even if the tet dose had been administered there would have been the same risk[^443]. Thus, the damage must occasioned by reason of negligence of the practitioner, if a person suffers damage due to natural causes, it cannot be said to be negligence[^444].

B. The damage must be recognised by law: Only the damage which is recognised by law that becomes the component of the negligence. Mere ordinary emotions of anxiety, grief or fear do not have force in law. There should be some serious mental disturbance outside the range of normal human experience[^445]. In medical negligence litigation, even a pure financial loss is not recoverable damage unless it is coupled

[^442]: Supra n 387.
[^445]: Page Vs Smith (19960 AC 155; (1995)2 All ER 736.)
with physical injury\textsuperscript{446}. In \textit{M} (a minor) Vs Newham London Borough Council, it is said that psychiatric damage is not damage which the law recognise as compensatable injury\textsuperscript{447}.

\textbf{C. The damage must fall within the foreseeable area of risk created by the breach of duty:} It is not sufficient to prove that there has been negligence or breach of duty and breach of duty has caused the loss, it is equally important to establish that the damage was not too remote but it was reasonably foreseeable consequence of the negligent act. Here, concepts of reasonable foreseeability and remoteness are relatively complex issues; both can be applied in determining the question of whether there is a duty of care owed by one to another\textsuperscript{448}. In \textit{Hyde Vs Tameside Area Health Authority}, a patient suffered severe paralysis due to his attempt to commit suicide out of depression under the wrong belief that he was contracted by cancer was going to die. The court found that the patient’ suicide attempt was too remote consequence of error made by the doctor\textsuperscript{449}.

\textbf{3.4.2.4. CONCLUSION:} 

The foregoing discussion shows that in order to constitute medical negligence there must be three essential elements such as

a) Duty of care on the part of the health care provider;

b) Breach of duty and

c) Consequential damage with the proximate cause.

The test for determining whether there has been breach do duty to take care on the part of the health care is the conduct of ordinary and competent medical practitioner in the relevant field. A medical practitioner is not guilty of negligence if he has acted in accordance with the practice accepted as proper by the opinion of the peer panel of the medical body. This is popularly called \textit{Bolam’s} case. The common law does not demand the highest standards of care and skill even for highly specialised kind of work within the medical profession. It is sufficient if the


\textsuperscript{447} (1995)2 AC 633.

\textsuperscript{448} Supra n 429.

\textsuperscript{449} (1981) Times, 16 April CA.
practitioner exercises the ordinary skill of an ordinary competent man exercising that particular art. The Bolam’s case has been accepted as authority of law in deciding the cases involving the issue of treatment, diagnosis and disclosure of information etc. However, the court of law in India has failed to evolve its own test to determine the standard of care of the medical practitioner. The Bolam’s case is not resulted from the conflict between two litigants, rather the confrontation between the medical profession as a whole and the interest of individual patient. Nonetheless the court plays a significant role in analyzing the issue of what amounts or what does not amount to medical negligence while examining the case of medical treatment.