CHAPTER I

MEDICAL NEGLIGENCE IN INDIA

Medical law and health law are the subject matter of this study. Medical negligence is a branch of medical law and covers all medical activity on the view of carelessness and rashness. The aim of this thesis is not to study the legal aspects of medical activity but it is concern all about conduct. It means that this paper is about the conduct of medical players vis; physicians, nurses, hospitals and any permitted person who is engaged in medical service. For example, the study does not analyze Health Service Act or Organ Transplant Act but it attempt, to investigate the process of rendering the medical service or the process of transplantation of an organ. The research is based on the description of medical conduct or the quality of action. In this context, negligence may be considered as an adjective for a conduct. So the main attempt in this research, in accordance to Iranian and Indian law, is introducing and explaining of what negligence is and how a conduct may be considered having negligence character.

1.1. Tort law

Winfield\(^1\) has defined negligence as a tort which is the breach of a legal duty to take care which results in damage, undesired by the defendant to the plaintiff. An act involving the above ingredients is a negligent act.

Baron Alderson defines negligence in *Blyth v. Birmingham Water Works Company*\(^2\) as omission to do something which a reasonable man guided upon by those consideration which ordinarily regulate human affairs, would do, or doing something which prudent and reasonable man would not do. Charlesworth modifies Alderson's definition and defines negligence as a tort which involves a person's breach of duty that is imposed upon him to take care; resulting in damage to the complainant.\(^3\) The breach of duty may be occasioned either by not doing something which a reasonable man, under given set of

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\(^2\) *Blyth v. Birmingham Water Works Company*, (1856) 21 Ex 781.
circumstances, would do, or by doing some act which a reasonable prudent man would not do.\(^4\)

History shows that the perception about Medical negligence has shifted from crime to Tort approach. In earlier civilization (code of Hammurabi developed by Babylon's King some 20 Centuries before Christian era) doctor's hands were cut off if the patient died during operation; Likewise issue of Medical negligence could be found in Islamic law, Mosaic law, *charaka samhita, sushruta samhita, Manuscriti, Kattirya's Arthashastre, yajnavllga, s smriti*.) Medical negligence was considered more as a crime than as a tort.

With the progress of civilization, medical negligence was increasingly treated as a tort by the judiciary so that the victim can be provided with damages. As common law evolved in England, the earliest recorded action against a medical man was mounted in 1374 when a surgeon, J Mort, was brought before the King's Bench considering his treatment of an injured hand. He was in fact held not liable, but the court said that if such a patient proved negligence, the court would provide a remedy.

Medical negligence is the failure of a medical practitioner to provide proper care and attention and exercise those skills which a prudent, qualified person would do under similar circumstances. It is a commission or omission of an act by a medical professional which deviates from the accepted standards of practice of the medical community, leading to an injury to the patient. It may be defined as a lack of reasonable care and skill on the part of a medical professional with respect to the patient, be it his history taking, clinical examination, investigation, diagnosis, and treatment that has resulted in injury, death, or an unfavorable outcome. Failure to act in accordance with the medical standards in vogue and failure to exercise due care and diligence are generally deemed to constitute medical negligence.\(^5\)

Everyone is responsible, not only for the result of his or her willful acts, but also for an


injury occasioned to another by his or her want of ordinary care or skill in the management of his or her property or person. Negligence is not the act itself, but the fact which defines the character of the act, and makes it a legal wrong.\(^6\) In common law, negligence is a complex relationship, a space, more than a “thing” a shifting, malleable, interaction between time and place and, to varying degrees, society, law, ethics, and professionals. The elements of a cause of action in tort of negligence are: (1) a duty to use ordinary care; (2) breach of that duty; (3) approximate causal connection between the negligent conduct and the resulting injury and (4) resulting damage.\(^7\) Negligence as a tort is the breach of a legal duty to take care, which results in damage undesired by the defendant, to the plaintiff. In essence, negligence consists of failure to take reasonable precautions against risks of injury to others, which one ought to have foreseen and guarded against. Negligence involves behaving in a manner that lacks the legality of protecting other people against foreseeable risks. It is a Tort. Tort is a civil wrong committed by one person on another. The word “Person” is the important issue in negligence. Fictional persons cannot be negligent though they may be held liable vicariously. In a negligence lawsuit the tortfeasor who committed the wrong is a person.

Negligence in law is the failure to meet a standard of behavior established to protect society against unreasonable risk. It is the cornerstone of tort liability and a key factor in most personal injury and property's damage trials. The doctrine of negligence does not require the elimination of all risk from a person's conduct, only all unreasonable risk, are required to be eliminated, which is measured by the seriousness of possible consequences. Thus, a higher standard applies to nitroglycerin manufacturers than to those making kitchen matches. In certain critical fields, e.g. the milk industry, the law imposes liability for every mistake, even when the strictest precautions are taken, a policy known as strict liability. Car accidents are a common source of legal liability. In almost all accidents, someone will be found responsible for failing to act as they should. Most

accidents result in damage to the vehicles or injury to people in them, and these are clearly a direct result of the accident. Negligence excludes wrongful intention since they are mutually exclusive. Carelessness is not culpable or a ground for legal liability except in those cases in which the law has imposed the duty of carefulness. Negligence may be in action or in omission.

Generally, no duty is imposed with respect to pure omissions when there is no legal duty to act, i.e. situations in which a defendant who has created no danger to the claimant merely fails to prevent him from sustaining harm. There are a number of reasons for this. One is the large number of potential defendants in situations of failure to act. Another is society’s focus on the more modest aim of discouraging wrongdoing rather than on the more ambitious one of encouraging good deeds. For these and other reasons, there is, for example, ordinarily no duty to rescue even when such an act could be carried out without personal risk. Explaining the meaning and scope of duty for negligence Alderson B stated that:

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. The defendants might have been liable for negligence, if, unintentionally, they omitted to do that which a reasonable person would have done, or did that which a person taking reasonable precautions would not have done. A reasonable man would act with reference to the average circumstances of the temperature in ordinary years. The defendants had provided against such frosts as experience would have led men, acting prudently, to provide against; and they are not guilty of negligence, because their precautions proved insufficient against the effects of the extreme severity of the frost of 1856, which penetrated to a greater depth than any which ordinarily occurs south of the polar regions. Such a state of circumstances constitutes a contingency against which no reasonable man can
provide. The result was an accident, for which the defendants cannot be held liable.\(^8\)

However, there will be a duty to act to prevent harm in certain situations, e.g. 1. Where the defendant and the claimant are in a special relationship of dependence such as guardian/child, carrier/passenger, employer/employee/physician/ patient,  2. Where the defendant has control over something which, or someone who, poses a threat to the claimant; or  3. Where the defendant has assumed responsibility for the claimant or his property.

In legal sense medical negligence is a subset of professional negligence which is a branch of the general concept of negligence that applies to the situation in which physician who represented himself or herself having special knowledge and art, breach’s his or her duty to take care about his or her patient. The general rules apply in establishing that the physician who owed the duty of care is in breach of that duty. Once the physician has accepted to treat the patient, the legal relationship between physician and patient is created, this means a medical relationship is established and this relationship resulted in duty to take care. The base of this legal relationship is the rule of "reasonable reliance" by the claimant on the skills of the defendant. Dealing with the question of duty to take care, the court observed:

Where a person is so placed that others could reasonably rely upon his judgment or his skill or upon his ability to make careful inquiry, and a person takes it upon himself to give information or advice to, or allows his information or advice to be passed on to, another person who, as he knows or should know, will place reliance upon it, then a duty of care will arise.\(^9\)

According to common law system of negligence, the medical practitioner has discretion in choosing the treatment which he proposes to give to the patient and such discretion is wider in cases of emergency, but, he must bring to his task a reasonable degree of skill

\(^8\)Supra n. 2.
and knowledge and must exercise a reasonable degree of care according to the circumstances of each case. A physician who holds himself out ready to give medical advice and treatment impliedly holds out that he is possessed of skill and knowledge for such purpose. Then, when he is consulted by a patient, owes certain duties, namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give, and a duty of care in the administration of that treatment. The criterion for existence of duty of care in giving advice was explained by the court in more restricted terms as:

What can be deduced from the Hedley Byrne case, therefore, is that the necessary relationship between the maker of a statement or giver of advice (the adviser) and the recipient who acts in reliance on it (the advisee) may typically be held to exist where (1) the advice is required for a purpose, whether particularly specified or generally described, which is made known, either actually or inferentially, to the adviser at the time when the advice is given, (2) the adviser knows, either actually or inferentially, that his advice will be communicated to the advisee, either specifically or as a member of an ascertainable class, in order that it should be used by the advisee for that purpose, (3) it is known, either actually or inferentially, that the advice so communicated is likely to be acted on by the advisee for that purpose without independent inquiry and (4) it is so acted on by the advisee to his detriment.

So an individual may owe a duty of care to another, to ensure that they do not suffer any unreasonable harm or loss. If such a duty is found to be breached, a legal liability is imposed upon the owner’s of the duty, to compensate the victim for any losses they incur.

Negligence mechanism is a great development at common law which occurs throughout

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The root of professional negligence can be found in the case of *Donoghue v. Stevenson*, where a woman succeeded in establishing that a manufacturer of ginger beer owed her a duty of care, where it had been negligently produced. Following this, the duty concept has expanded into a coherent judicial test, which must be satisfied in order to claim in negligence. A medical professional is expected to have the requisite degree of skill and knowledge. The rule in professional negligence is a little different, for professionals such as medical practitioners an additional perspective is added through a test known as the *Bolam* test which is the accepted test in India.

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.

This approach has been accepted in the judgment of the Indian Supreme Court in the case of *Jacob Mathew v. State of Punjab*. The standard of care, when assessing the practice as adopted is judged in the light of the knowledge available at the time of the incident, and not at the date of trial. The Supreme Court in United States has also set forth a two-part test in *Bryant v. Oakpointe Villa Nursing Center*. The Supreme Court stated the following two-part test for distinguishing between ordinary negligence claims and professional negligence:

Therefore, a court must ask two fundamental questions in determining whether a claim sounds in ordinary negligence or medical malpractice:

1. Whether the claim pertains to an action that occurred within the course of a professional relationship; and

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15 *Bolam v. Friern Hospital Management Committee*, [1957] 1 WLR.
16 Supra n10.
(2) Whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience. If both these questions are answered in the affirmative, the action is subject to the procedural and substantive requirements that govern medical malpractice actions.\textsuperscript{18}

The Indian civil law on negligence essentially is the judge made common law followed in England for centuries. In the conduct of professions, the law allows for a variety of levels of qualification, and thus a variety of standards, as long as the level of expertise which can be expected from any given professional is readily apparent from his particular qualification e.g. that he is a general practitioner rather than a specialist. However, every professional must achieve an acceptable level of basic competence. When assessing whether or not a professional has been negligent, the courts will normally use as their benchmark the common practice within the relevant profession. However, where they consider that a profession adopts an unjustifiably lax practice, they may condemn the common standard as negligent.\textsuperscript{19} The court observed:

A professional relationship sufficient to support a claim of medical malpractice exists in those cases in which a licensed health care professional, licensed health care facility, or the agents or employees of a licensed health care facility, were subject to a contractual duty that required that professional, that facility, or the agents or employees of that facility, to render professional health care services to the plaintiff. After ascertaining that the professional relationship test is met, the next step is determining whether the claim raises questions of medical judgment requiring expert testimony or, on the other hand, whether it alleges facts within the realm of a jury's common knowledge and experience. If the reasonableness of the health care professionals' action can be evaluated by lay jurors, on the basis of their common knowledge and experience, it is ordinary negligence. If, on the other hand, the reasonableness of the action can be evaluated by a jury only after

\textsuperscript{18}\textit{Ibid.}

having been presented the standards of care pertaining to the medical issue before
the jury explained by experts, a medical malpractice claim is involved.20

In ordinary negligence cases, the court is fully competent to lay down what the
reasonable man should do in everyday circumstances as judges are aware of and
understand everyday circumstances. But in cases of medical negligence, intricacies of
medical science are not, generally speaking, within judicial knowledge. The judge may
not be able to measure the reasonableness of medical activity of which he has no great
level of understanding. Medicine is perhaps the classic example of a profession in which
results are not guaranteed and are not expected to be guaranteed.21

The concept of negligence is central to the tort system of liability. The negligence
concept is centered on the principle that every individual should exercise a minimum
degree of ordinary care so as not to cause harm to others. Everyone is responsible, not
only for the result of his or her willful acts, but also for an injury occasioned to another
by his or her want of ordinary care or skill in the management of his or her property or
person. "Negligence is not the act itself, but the fact which defines the character of the
act, and makes it a legal wrong."22 Negligence is a basis for a wide variety of legal claims
in the law of torts. Medical negligence is often confused for medical malpractice, when in
fact; negligence is only one aspect of a meritorious medical malpractice claim.
Negligence can occur at various stages. A health care provider may misdiagnose a
problem, fail to treat the injury or illness properly, administer the wrong medication, and
fail to adequately inform a patient about the risks of a procedure or about alternative
treatments. Medical negligence comprises the majority of professional negligence
lawsuits. This is not to say that medical professionals are more prone to committing
negligence, but that they are the target of more professional negligence lawsuits. The
legal position of medical negligence in India has been described in several leading

20_Supra n17.
21_Jackson & Powell, Medical Negligence Litigation: Time for Reform, PS Ranjan, Medical Law and Ethics.
22_Supra n 6.
judgments. In the leading case *Bolam v. Friern Hospital Management Committee*\(^{23}\) McNair J. has stated as follows:

…………….. where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of 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 well-established law that it is sufficient if he exercise the ordinary skill of an ordinary competent man exercising that particular art. Counsel for the plaintiff put it in this way, that in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards then he is not negligent. 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. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion.

The Supreme Court in *Laxman v. Trimbak*\(^{24}\), held:

The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when

\(^{23}\) *Supra* n15.

consulted by a patient owes him certain duties viz., a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.

In *Achutrao Haribhau Khodwa v. State of Maharashtra*\(^2^6\) the Supreme Court said:

The skill of medical practitioners differs from doctor to doctor. The very nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession and the Court finds that he has attended on the patient with due care skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence.

In a case Apex Court has specifically laid down the following principles for holding doctors negligent:

Gross medical mistake will always result in a finding of negligence. Use of wrong drug or wrong gas during the course of an anesthetic will frequently lead to the imposition of liability and in some situations even the principle of res ipsa loquitur can be applied. Even delegation of responsibility to another may amount to negligence in certain circumstances. A consultant could be negligent where he


delegates the responsibility to his junior with the knowledge that the junior was incapable of performing of his duties properly. We are indicating these principles since in the case in hand certain arguments had been advanced in this regard, which will be dealt with while answering the question posed by us.²⁷

1.2. Element of medical negligence

The tort of negligence is the most frequently used of all torts and it is thus the most important tort in modern law. Negligence protects against three types of harm:

(i) Personal injury,

(ii) Damage to property and

(iii) Economic loss

There is some debate as to whether negligence is a tort or a basis of liability. Negligence is a tort which determines legal liability for careless actions or inactions which cause injury.

It must be taken on account that action or inaction is not the subject matter of negligence in itself; it means negligence is concerned with the manner in which the activity is carried out. The duty of care for a medical professional starts from the time the patient gives an implied consent for his treatment and the medical professional accepts him as a patient for treatment, irrespective of financial considerations. This duty starts from taking the history of the patient and covers all aspects of the treatment, like writing proper case notes, performing proper clinical examination, advising necessary test and investigations, making a proper diagnosis, and carrying out careful treatment.²⁸

Negligent conduct is that which falls below an acceptable standard. This standard is established in order to protect others from an unreasonable risk of harm. However, not every type of careless behavior will constitute the legal action of negligence. As per P. H.

²⁸Supra n. 5.
Winfield, negligence means; the breach of a legal duty to take care by an inadvertent act or omission that injures another.  

Negligence is concerned with compensating people who have suffered damage as a result of the carelessness of other people. But the law does not provide a remedy for everyone who suffers in this way. This is where the doctrine of the duty of care plays a role. A person will only be liable to another for negligence if she has a duty of care towards the other and she has breached that duty and caused damage to the other. A speeding car knocked down a cyclist and killed him. A patient mistakenly gets injected with the wrong antibiotic causing permanent paralysis by her junior doctor. An elderly woman breaks her hip after tripping over a raised paving slab on the pavement outside her local shop. A young child falls down a manhole left uncovered by Post Office employees earlier in the day and seriously injures his leg. In each of these examples, the accident or injury suffered appears to be the fault, at least in part, of someone other than the injured party. The speeding motorist, the junior doctor, the local authority and the Post Office employees have all been, in some way, negligent, in the sense of having acted carelessly or negligently. Negligence is a basis for a wide variety of legal claims in the law of torts. It is best to think of tort law as civil injury law. A common example of tort law, and a familiar way to explain how negligence works, is to think of drivers on the road, rules of the road and car accidents. In a car accident, it is usually established that one person caused the accident, and that person is responsible to pay for all the damages incurred to the other parties involved.

In terms of medical malpractice tort law, medical negligence is usually the basis for a lawsuit demanding compensation for an injury caused to a patient by a doctor or other medical professional. While negligence on its own does not merit a medical malpractice claim, when the negligence results in undue injury to a patient, a lawsuit may be brought demanding compensation for all associated damages. A physician has a duty to diagnose and treat his or her patients using the standard of care of other similarly trained

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physicians in that community. If a physician fails to diagnose cancer when another physician in that community with similar training would have been expected to diagnose the cancer, that physician may be liable if the delay in diagnosis results in severe case than if the cancer had been detected and treated at an earlier stage. The unsatisfactory outcome of medical treatment in itself is insufficient to support an allegation that the doctor treating a patient was negligent. Then the patient cannot sue his doctor for medical negligence simply because his illness cannot be cured after a series of treatments. Medical negligence occurs when a medical provider fails to exercise the kind of care and prudence that other providers in the same field of medicine provide. Medical negligence can occur in the form of recklessness, inattentiveness, or an omission. Common types of malpractice include misdiagnosis, failure to provide proper treatment of a patient's ailment, administration of the wrong medication, and the failure to inform the patient of the risks associated with a treatment or with information about alternative treatments.

Tort law governs medical negligence. To establish that a provider's negligence was malpractice, a claimant must establish the following:

a. The healthcare provider owed a duty to the plaintiff;

b. The healthcare provider breached the duty;

c. The healthcare provider's breach caused the injury; and

d. The patient suffered damages because of the defendant's negligence.

Medical negligence occurs when a doctor, dentist, nurse, surgeon or any other medical professional performs his job in a way that deviates from the accepted medical standard of care. In keeping with car accident analogy, if a doctor breaks the rules regarding how to treat a patient, and does something that is "against the rules", then that doctor has failed to perform his duty, and is said to be negligent.

1.2.1. Duty of care

The rules as to the duty of care in medical negligence cases are the same as the rules
applicable to all other kinds of negligence. Common law recognizes four basic levels of fault: negligence, recklessness or wanton conduct, intentional misconduct, and strict liability (irrespective of fault). Negligence generally means careless or inadvertent conduct that results in harm or damage. It is a recurring factor in an aggregate majority of accidental damages. It encompasses both active and passive forms of fault. That is to say, failing or omitting to do something may result in liability just as much as actively doing something wrong. Reckless or wanton conduct generally refers to a willful disregard for whether harm may result and or a disregard for the safety and welfare of others. Strict liability may be imposed, even in the absence of fault, for accidents involving certain defective products or extra hazardous activities. In common law duty is the base of liability of a person to be punished, forced to compensate, or otherwise subjected to a sanction by the law. There are many grounds on which responsibility may be imposed, and others may be invented in the future, but those which have featured in legal systems up to now can be classified according to three criteria.

The first is the conduct of the person held responsible: is he responsible on account of his conduct, or is he held responsible irrespective of his conduct?

The second is causal connection. When a person is to be held responsible for harm, must it be shown that his conduct caused the harm? Or is it sufficient that he occasioned it, e.g. by providing an opportunity for the harm to be done? Or can he be held responsible in the absence of any such connection?

The third is fault. Can a person be held responsible only when he is shown to have been at fault or can he be held responsible even in the absence of fault, i.e. on the basis of strict liability?

Under common law, a physician has traditionally not been required to undertake the care of someone who is not already a patient. This reflects the position that no person is required to provide assistance to another except in exceptional circumstances.30

duty is very concern to what is a right; a right is a special advantage that someone gains because of his or her particular status. The special advantage might include gaining a liberty, a power, an entitlement, or immunity. The particular status might include one's status as a human being, a woman, a minority, an animal, a child, or a citizen of some country. This general notion of right applies in both legal and moral contexts.  

In English law, there is a little or even no theory with regard to rights, this could be because it has traditionally preferred to look at things from the defendant’s, rather than the claimant's, point of view. That is to say, the key to ‘right’ might not to be found in the word right itself, but in the notion of ‘duty’, a notion which could be seen simply as the correlative of a right. Duty implies the language of the law of obligations rather than the law of property, and this is why one talks about a duty to another rather than a right to something. It is difficult to come up with a comprehensive formula for, or list of, all the duties. The essential point is that the problem is not in existence of a duty in itself but in defining the duty where such a duty is recognized. Attempts have been made to define the duty through the courts, mainly through the device of the implied term, but these attempts have run into conceptual difficulties, although they have provided valuable insights into the nature and scope of the problem. Practitioners who do attempt to find a practical definition find out how difficult a mutually acceptable solution is to achieve, which is why, in practice, there are few model cases available. Hence the reason is that there are a few definitions at the legislative and institutional levels.

In civilian legal thought, a legal institution is regarded as a social reality around which rules are framed. All legal rules attach themselves to a person, to a thing or to a legal remedy. These institutions have a role not only in organizing the law but also in organizing the facts themselves. Legal institutions are fundamental both to problem-solving and to legal reasoning. They are the vehicle both by which facts are categorized so that the law can be applied and by which the law itself is structured so as to render it

31 Samuel, G, Epistemology and legal institutions, IJSL 3091991.
capable of being applied in the first place.\textsuperscript{34} Thus, the parties (legal subjects), property (legal objects) and remedies (actions) are now the main starting points in analyzing legal liability in the common law; and each of these institutions is capable of generating its own particular case law and sets of legal rules. Yet, what is important to bear in mind is that the institutions are also fundamental to the analysis and categorization of the facts themselves. They can go some way in actually determining the rules that find them being applied.\textsuperscript{35} The recognition by the law of new interests is simply the application of a traditional scientific structure to new social circumstances.

A right is a construct of legal science, it takes its form from the relationship between persona and res and this is the reason why one always talks of a right to something.\textsuperscript{36} A preexisting relationship may create an affirmative duty. Right and duty are very correlatives, but in common law duty is more subtle than right, it is because duty is derived from obligation. Duty is not such express concept; it varies from situations and relationship. Take these examples in account:

The Highways Act 1980 stipulates that;

   The authority ... is under a duty ... to maintain the highway’.\textsuperscript{37} However, ‘in an action against a highway authority in respect of damage resulting from their failure to maintain a highway ... it is a defense ... to prove that the authority had taken such care as in all the circumstances was reasonably required ...\textsuperscript{38}

The Environmental Protection Act 1990 states that;

\textsuperscript{34}Samuel, G, \textit{Foundations}, pp 171–90.
\textsuperscript{35}Supra n 30.
\textsuperscript{36}Picard EI, Robertson GB. \textit{Legal liability of doctors and hospitals in Canada}. p. 174, Scarborough, Cars well; 1996.
\textsuperscript{37}Highways Act 1980, s 41.
\textsuperscript{38}Goodes \textit{v East Sussex CC} [2000] 1 WLR 1356 (HL).
It shall be the duty of any person, who imports, produces, carries, keeps, treats or disposes of controlled waste... to take all such measures applicable to him in that capacity as are reasonable in the circumstances.  

The Health and Safety at Work Act 1974 lays down that it;

…Shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare of work of all his employees.

The Defective Premises Act 1972 states that;

a person taking on work for or in connection with the provision of a dwelling ... owes a duty ... to see that the work which he takes on is done in a workmanlike or, as the case may be, professional manner, with proper materials and so that as regards that work the dwelling will be fit for habitation when completed.

Finally, one might recall the Occupiers Liability Act 1957; this Act says that an occupier;

Owes the same duty, the ‘common duty of care’, to all his visitors.

And this duty is defined as;

A duty to take such care as in all the circumstances of the case is reasonable to see that the visitor will be reasonably safe.

These examples illustrate that the ‘duty’ is more ambiguous and the content of the duty may have to be determined either by relating one section to another or by carefully scrutinizing the language of the section in order to see if there is a qualification to the duty. This can raise a substantive and a procedural question. Upon whom should be the burden of proof when it comes to an expression such as ‘reasonably practical’? In the law

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39Environmental Protection Act 1990, s 34(1).
40Health and Safety at Work Act 1974, s 2.
41Defective Premises Act 1972, s 1(1).
42Occupiers’ Liability Act 1957, s 2(1).
43Occupiers’ Liability Act 1957, s 2(2).
44Nimmo v Alexander Cowan, AC 107, 1968.
of negligence, the concept of duty of care has given rise to the great confusion since the presence of it in a particular case is often explained by saying that, in the circumstances, the defendant owed a duty of care to the plaintiff. In fact nobody knows what is meant by duty of care, it means different things in different circumstances like in accident there is changing factual scenario as the scope of the circumstances provided in various situations, and there is a high level of judicial disagreement regarding the underlying legal principles at least in those circumstances.

An individual may owe a duty of care to another, despite there being no prior relationship or interaction. The House of Lords established a modern form of the tort of negligence in English law, by setting out general principles whereby one person would owe another person a duty of care. The Court has proceeded on the general principle that in an ordinary case a manufacturer is under no duty to any one with whom he is not in any contractual relation. To this rule there are two well known exceptions: where the article is dangerous per se\textsuperscript{45}, and where the article is dangerous to the knowledge of the manufacturer\textsuperscript{46}, but the appellant submits that the duty owed by a manufacturer to members of the public is not capable of so strict a limitation, and that the question whether a duty arises independently of contract depends upon the circumstances of each particular case. The court decided that when a manufacturer puts upon a market an article intended for human consumption in a form which precludes the possibility of an examination of the article by the retailer or the consumer\textsuperscript{47}, he is liable to the consumer for not taking reasonable care to see that the article is not injurious to health.\textsuperscript{48} Lord Atkin laid down the neighbour rule and held;

"You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be - persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being

\textsuperscript{45}George v. Skivington (L. R. 5 Ex. 1.)
\textsuperscript{46}Heaven v. Pender 11 Q. B. D. 503, 509 et seq.
\textsuperscript{47}ib.
\textsuperscript{48}Dominion Natural Gas Co. v. Collins Perkins. A. C. 640, 646, 1909."
so affected when I am directing my mind to the acts or omissions which are called in question…⁴⁹

Dealing again with the question of duty to take care in nervous shock cases the House of Lords held;

such a duty only arises towards those individuals of whom it may be reasonably anticipated that they will be affected by the act which constitutes the alleged breach…Can it be said that John Young could reasonably have anticipated that a person, situated as was the appellant, would be affected by his proceeding … at the speed at which he was travelling? I think not. His road was clear of pedestrians. The appellant was not within his vision, but was standing behind the solid barrier of the tramcar. His speed in no way endangered her. In these circumstances I am unable to see how he could reasonably anticipate that, if he came into collision with a vehicle coming across the tramcar …, the resultant noise would cause physical injury … to a person standing behind the tramcar. In my opinion, he owed no duty to the appellant, and was, therefore, not guilty of any negligence in relation to her …”⁵⁰

The Donoghue⁵¹ case established a duty of care for manufacturers. Following this case, the duty of care was extended, case-by-case, to a number of different relationships. Before Donoghue v Stevenson⁵² the idea of individuals owing strangers a duty of care where beforehand such duties were only found from contractual arrangements developed at common-law, following this, the duty concept has expanded into a coherent judicial test, which must be satisfied in order to claim in negligence. It was held;

The foundation of the appellant's claim is fault or negligence alleged against John Young, an allegation which postulates a breach by him of some duty owed by him to her. Therefore, the first essential for the appellant to establish is the existence

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⁴⁹ Supra n 14.
⁵⁰ Bourhill v Young [1943] AC 92.
⁵¹ Supra n. 14.
⁵² Supra n. 14.
of a duty owed to her by John Young of which he committed a breach. As between John Young and the driver of the motor-car, John Young was admittedly negligent, in that he was in breach of the duty which he owed to him of not driving … at such a speed as would prevent him from pulling up in time to avoid a collision … but it by no means follows that John Young owed any duty to the appellant. The facts relevant to this question seem to me to be these: The appellant was not in any way physically involved in the collision. She had been a passenger in [a] tramcar which had come from the direction of the city and had stopped some fifteen or sixteen yards short of the point of collision. She was standing in the road on the off-side of the tramcar (which was at rest), with her back to the driver's platform. The front part of the tramcar was between her and the colliding vehicles. She was frightened by the noise of the collision, but she had no reasonable fear of immediate bodily injury to herself. In considering whether a person owes to another a duty a breach of which will render him liable to that other in damages for negligence, it is material to consider what the defendant ought to have contemplated as a reasonable man … It will be sufficient in this connection to cite two passages from well known judgments. The first is from the judgment of Brett M.R. in Heaven v Pender: Whenever one person is by circumstances placed in such a position with regard to another that every one of ordinary sense, who did think, would at once recognize that if he did not use ordinary care and skill in his own conduct with regard to those circumstances he would cause danger of injury to the person or property of the other, a duty arises to use ordinary care and skill to avoid such danger.53

The "neighbor" principle, which was derived from the Christian principle of "loving your neighbor"54 is the most famous section of Lord Atkin’s judgment, he argued that:

53Id.
54The parable of the Good Samaritan is a parable told by Jesus and is mentioned in only one of the Canonical gospels. According to the Gospel of Luke (10:25-37) a Jewish traveler is beaten, robbed, and left half dead along the road. First a priest and then a Levite come by, but both avoid the man. Finally, a Samaritan comes by. Samaritans and Jews generally despised each other, but the Samaritan helps the
The sole question for determination in this case is legal: Do the averments made by the pursuer in her pleading, if true, disclose a cause of action? I need not restate the particular facts. The question is whether the manufacturer of an article of drink sold by him to a distributor, in circumstances which prevent the distributor or the ultimate purchaser or consumer from discovering by inspection any defect, is under any legal duty to the ultimate purchaser or consumer to take reasonable care that the article is free from defect likely to cause injury to health. I do not think a more important problem has occupied your Lordships in your judicial capacity: important both because of its bearing on public health and because of the practical test which it applies to the system under which it arises...in order to support an action for damages for negligence the complainant has to show that he has been injured by the breach of a duty owed to him in the circumstances by the defendant to take reasonable care to avoid such injury. In the present case we are not concerned with the breach of the duty; if a duty exists, that would be a question of fact which is sufficiently averred and for present purposes must be assumed. We are solely concerned with the question whether, as a matter of law in the circumstances alleged, the defender owed any duty to the pursuer to take care.55

The rule governing liability for pure economic loss not arising from a contractual relationship is based on "assumption of responsibility". The notion that a party may owe another a duty of care for statements made in reliance had been rejected prior to the

injured Jew. Jesus is described as telling the parable in response to a question regarding the identity of the "neighbor" which Leviticus 19:18 says should be loved. Portraying a Samaritan in positive light would have come as a shock to Jesus' audience.[1] It is typical of his provocative speech in which conventional expectations are inverted. Some Christians, such as Augustine, have interpreted the parable allegorically, with the Samaritan representing Jesus Christ, who saves the sinful soul. Others, however, discount this allegory as unrelated to the parable's original meaning, and see the parable as exemplifying the ethics of Jesus, which have won nearly universal praise, even from those outside the Church. The parable has inspired painting, sculpture, poetry, and film. The colloquial phrase "good Samaritan," meaning someone who helps a stranger, derives from this parable, and many hospitals and charitable organizations are named after the Good Samaritan. 55Supra n. 14.
decision of *Hedley Byrne and Co Ltd v Heller & Partners Ltd*\(^56\), with the reason that only remedy for such losses being in contract law. The House of Lords overruled the previous position, in recognizing liability for pure economic loss not arising from a contractual relationship, introducing the idea of "assumption of responsibility". The court found that the relationship between the parties was "sufficiently proximate" as to create a duty of care. It was reasonable for them to have known that the information that they had given would likely have been relied upon for entering into a contract of some sort. This would give rise, the court said, to a "special relationship", in which the defendant would have to take sufficient care in giving advice to avoid negligence liability. However, on the facts, the disclaimer was found to be sufficient enough to discharge any duty created by Heller's actions. In positioning the physician’s duties to their patient in negligence theory, the English courts have fastened upon his assumption of responsibility for the patient welfare, coupled with the representation of specialist knowledge and skill. It was accepted way back in 1925 that:

> if a person holds himself out as possessing special skill and knowledge, and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his discretion and treatment accordingly, he owes a duty to the patient . . . No contractual relation is necessary, nor is it necessary that the service be rendered for reward.\(^57\)

### 1.2.2. Breach of duty

There can be no liability in negligence without establishing both duty of care and that there has been a breach of that duty, the standard of care is reasonable conduct under the circumstances.

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\(^{56}\) *Supra* n. 9.

\(^{57}\) *R v Bateman*, 19 CAR 8, 1925.
A doctor has a legal duty to take care of his patient. Whenever a patient visits a doctor for treatment there is a contract by implication that the doctor will take reasonable care to treat him. If there is a breach of that duty and if it results in injury or damage, the doctor will be held liable. The doctor must exercise a reasonable degree of care and skill in his treatment; but at the same time he does not and cannot guarantee cure. In other words, a doctor is only required to ensure due care in treating the patient. Liability in case of medical negligence arises not when the patient has suffered an injury but when the injury has resulted due to the conduct of the doctor which has fallen below the standard of reasonable care. The skill of medical practitioners may differ from one doctor to another. There may be more than one course of treatment which may be given for treating a particular disease. Medical opinion may differ with regard to the course of action to be taken for treating a patient. As long as the doctor acts in a manner which is acceptable to the medical profession and he treats the patient with due care and skill, the doctor will not be guilty of negligence even if the patient does not survive or suffers a permanent ailment.\textsuperscript{58}

Negligence is defined as the failure to exercise the standard of care that a reasonable person would exercise in similar circumstances. The negligence occurs when someone suffers injury because of another's failure to live up to a required duty of care and is a primary cause of negligence suits. The concept of duty of care comes from a well-known case in which it was pointed that everyone should take reasonable care to avoid acts or omissions that are likely to injure their neighbors. The word neighbor in this sense does not simply refer to the person living next door, but includes any persons who are likely to be affected by your activities. In this regard, doctors and other medical practitioners normally owe a duty of care to their patients when they are administering medical treatment. Once a doctor or health care professional agrees to diagnose or treat a patient, he or she has assumed a duty of care toward that patient. What this means is that the health care professional must treat the patient with at least the same level of care as a

\textsuperscript{58} \textit{Supra} n. 5.
reasonably competent health care professional. Generally, a health care professional does not have a duty to someone who is not a patient. Professional negligence occurs whenever a professional improperly or unethically performs his or her duties either intentionally or out of carelessness. In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action. The *Donoghue*\(^n. 14\) case sets out requirements which a person must meet in order to bring a successful claim for negligence, which are; a duty of care, a breach of that duty and that the breach must have caused the harm in question. A duty of care contains certain obligations. This is the idea of the content of a duty of care, which observes what should be done or not be done to discharge that duty of care. To discover what should be done court need a yardstick by which to measure the content of the duty of care, some standard by which we can judge what should have been done. This yardstick is called the standard of care. The more stringent the standard, the harder it is to meet. In negligence, a claim can only really arise when the duty isn't satisfactorily discharged. This is the idea of the breach of the duty of care. To determine whether a breach of the duty of care has occurred, the Court determines what actually happened, i.e. the facts of the case, by taking evidence. It then compares what actually happened with the standard of care which is required by the law. If what actually happened falls below what should have happened, then the Court can conclude that a breach of the duty of care has occurred. The standard of care is a question of law. The advent of an adverse outcome alone does not establish the existence of breach of the duty of care. Breach of duty may be found to exist where the defendant fails to meet the standard required by law. Once it has been established that the defendant owed the claimant a duty of care, the claimant must also demonstrate that the defendant was in breach of duty. The test of breach of duty is generally objective; however, there may be slight variations to this. This is a legal responsibility not to cause harm. How do you test whether this act or failure is

\(^{59}\) *Supra* n. 14.
negligent in an ordinary case is generally said you judge it by the action of the man in the street. He is the ordinary man. In one case it has been said you judge it by the conduct of the man on the top of a Clapham omnibus. The man on the Clapham omnibus is a reasonably educated and intelligent but non-specialist person, a reasonable person, a hypothetical person against whom a defendant's conduct might be judged in an English law civil action for negligence. This is the standard of care comparable to that which might be exercised by "the man on the Clapham omnibus" mentioned by Lord Justice Greer in *Hall v. Brook lands Auto-Racing Club*60. This phrase was first put to legal use in a reported judgment by Sir Richard Henn Collins in the 1903 English Court of Appeal libel case, McQuire v. Western Morning News. He attributed it to Lord Bowen, said to have coined it as junior counsel defending the Tichborne Claimant case in 1871. Brewer's also lists this as a possible first use. He is the ordinary man. The law makes use of the concept of the reasonable man thereby ignoring the realities of the defendant’s situation in so far as they are different from the objective reasonable man standard. The standard of care required is the objective one of the reasonable man. He is a notional man who is neither too unduly apprehensive nor overconfident. Purpose of this theoretical ideal man is to ensure objectivity and uniformity and eliminate the personal idiosyncrasies of the person whose conduct is in question.

In deciding whether there has been a breach of the duty of care the tribunal of fact must first ask itself whether a reasonable man in the defendant’s position would have foreseen that his conduct involved a risk of injury to the plaintiff… If the answer is in the affirmative, it is then for the tribunal of fact to determine what a reasonable man would do… The perception of the reasonable man’s response calls for a consideration of the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have.61

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60 *Hall v. Brooklands Auto Racing Club*, 1933.
To disregard the particular idiosyncrasies and weaknesses of the defendant or person whose conduct is in question, it is the Trial Judge who will decide what is reasonable and what could have been foreseen. In the case of *Nettleship v. Weston*\(^{62}\) Court of Appeal deal with Learner-driver defendant crashed into lamp post causing injuries to the front seat passenger. Question was the standard of care required for the learner-driver. The court held that:

The standard for a learner-driver is the same as that required for any other driver. The driver’s “incompetent best is not good enough”. Her inexperience was considered to be irrelevant.

To determine the standard of care the court attempts to resolve the question as to whether:

- A reasonable person in the defendant’s position would have foreseen that their conduct posed a risk of injury to the claimant; and

- The reasonableness of the defendant’s response to the risk.

The reasonable person standard is an elastic concept that adapts to the situation faced by the Court. It will consider all the circumstances of the case before deciding which reasonable person standard yardstick is applicable in that case. For example, in general cases the reasonable person has been described as a passenger on the Underground.\(^{63}\) For cases involving persons possessing a particular skill, the reasonable person standard possesses the requisite skill to an ordinary level found in that profession. Liability only arises if the action breaches the duty of care and causes a loss or harm to the individual, which would have been reasonably foreseeable in all the facts and circumstances of the case. In order to seek compensation, the injured party must show that wrongdoer breached a duty to take care and it is not sufficient that he or she establishes that the defendant owed a duty of care, he or she must also show that the defendant breached that

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\(^{62}\) *Nettleship v. Weston*, 1971

\(^{63}\) *McFarlane v. Tayside Health Board*, 4 All ER 961, 1999.
duty. The test in general what the standard has adopted by law is what a reasonable person of ordinary prudence would have done in the same circumstances. In determining whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following:

(a) The probability that the harm would occur if care was not taken,
(b) The likely seriousness of the harm,
(c) The burden of taking precautions to avoid the risk of harm,
(d) The social utility of the activity that creates the risk of harm.

The objective standard is based on an average person. It does not require perfection, but takes into account that an average person does not foresee every risk. The average person is not assumed to be flawless, but ordinarily careful and prudent. A breach of a duty of care does not always give rise to liability in a negligence claim. Breach of duty is decided by the objective test i.e. the defendant is expected to meet the standard of a reasonable person. A potential defendant will be negligent by falling below the standards of the ordinary reasonable person in his/her situation, i.e. by doing something which the reasonable man would not do or failing to do something which the reasonable man would do. The most popular definition of the reasonable man is that he is the ordinary man, the average man, or the man on the Clapham omnibus.

The objective test can be variable and may depend on the circumstances of the particular defendant or the situation. In the context of 'horseplay', there is a breach of duty of care only where the defendant's conduct amounts to recklessness or a very high degree of carelessness. If the defendant is a professional he will be held to the standard of a reasonable person within that profession. This applies also to trainees. Likewise, a learner driver is expected to meet the same standard as a reasonable competent qualified driver,

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64 Supra n 2.
65 Vaughan v. Menlove, 3 Bing. N.C. 467, 1837.
66 Supra n 2.
67 Supra n 60.
otherwise be found in breach of duty.\textsuperscript{68}

Where there is divided opinion within a profession as to the appropriate course of action in a particular situation then a defendant is not to be treated as in breach of duty by following one body of opinion rather than the other.\textsuperscript{69} However, the opinion must be defensible and rooted in logic.\textsuperscript{70} A child is not expected to meet the standard of a reasonable adult, but will be judged by the standard of a reasonable child of the same age.\textsuperscript{71} The courts have not taken a consistent approach in relation to where the defendant's conduct is affected by illness.\textsuperscript{72} The inconsistencies are often explained on policy grounds; in the \textit{Roberts}\textsuperscript{73} case concerned personal injury was sustained by a pedestrian and thus a breach of duty was found in order to ensure the victim was compensated whereas \textit{Mansfield}\textsuperscript{74} involved property damage which would have been covered by insurance. If the reasonable person would not foresee a harmful consequence of an action, then a defendant will not be negligent in failing to take precautions.\textsuperscript{75} The court will consider the likelihood of harm occurring. The greater the risk of harm, need the greater the precautions that will have to be taken.\textsuperscript{76}

\textbf{1.2.3. The Anns test}

In \textit{Anns v Merton London Borough Council},\textsuperscript{77} a new two-part test was developed to determine whether the defendant owed a duty of care to the claimant. First it should be established that there is a sufficient relationship of proximity or neighborhood between the parties for damage to be a foreseeable possibility of any careless act or omission in which case a prima facie duty of care arises.

If this was established, then the court only had to decide whether there were any policy

\textsuperscript{68} \textit{Supra} n.62.
\textsuperscript{69} \textit{Supra} n. 15.
\textsuperscript{70} \textit{Bolitho v. City}, 3 WLR 1151, 1997.
\textsuperscript{71} \textit{Mullin v. Richards}, 1 WLR 1304, 1998.
\textsuperscript{72} \textit{Roberts v. Ramsbottom}, 1 WLR 823, 1980.
\textsuperscript{73} \textit{Id.}
\textsuperscript{74} \textit{Mansfield v. Weetabix}, EWCA, Civ, 1352, 1997.
\textsuperscript{75} \textit{Roe v. Minister of Health}, 2 All ER 131, 1954.
\textsuperscript{76} \textit{Bolton v. Stone}, 1 All ER, 1078, 1951.
\textsuperscript{77} \textit{Anns v. Merton London Borough Council}, AC 728, 1978.
considerations that might either limit the scope of the duty or remove it altogether. This was a change from the approach based on the test in Donoghue.\textsuperscript{78} Under the Donoghue\textsuperscript{79} test, where a factual situation could not be linked to precedent, a duty of care would only be held to arise if there were policy reasons for doing so. Under the Anns\textsuperscript{80} test, a prima facie duty of care would be held to arise where the defendant could reasonably be expected to foresee a risk of harm to the claimant, unless policy considerations dictated that no duty should exist.

For instance, in the case of Smith v Eric S Bush\textsuperscript{81}, the defendants were surveyors for a mortgagee. They performed a survey of the house, declaring it to need no significant repair. Relying on this, the house was conveyed to a purchaser. The chimney stack in the house subsequently fell down, and the purchaser sued for the negligent statement. It was held that even though the defendants had issued a liability waiver, this could not stand up to the Unfair Contract Terms Act1977's test of reasonableness. More importantly, however, the court held that it was not unreasonable for the purchaser of a modest house to rely on the surveyors' evaluation, as it was such common practice. In this way the court extended Hedley Byrne liability to proximate third parties.

There is however, a difference between standard of care on the one hand and degree of care on the other. In the case of a doctor, the standard of care expected of him remains the same in all cases, but the degree of care will be different in different circumstances. Thus while the same standard of care is expected from a generalist and a specialist, the degree of care would be different. A higher degree of skill is expected from a specialist when compared to that of a generalist.\textsuperscript{82}

What is a duty of care is up to the nature of the relationship between injurerd party and who incur losses, or the nature of the action, for example in relation between teacher and student teachers have a duty of care, or a responsibility to help all those who are linked to

\textsuperscript{78} Supra n.14.
\textsuperscript{79} Id.
\textsuperscript{80} Supra n.77.
\textsuperscript{82} Supra n 5.
them in the teacher-student relationship. This duty is just what it sounds like a duty or a responsibility binding the teacher to care for the student but it is not commonly described as the care that would be taken by a reasonable parent, because a better description of the care required, certainly with large groups, would be that the level of care should be that reasonably expected of a caring professional. In many cases, this might be somewhat more than is expected of a parent, and certainly some hazards that might be accepted at home might be unreasonable at school. Reflect a little on the activities that may have seen parents accepting, perhaps that a teacher himself has accepted, and then asks himself: Would I allow my students to do this? Often, the answer will be no, simply because, with regard to the nature of relationship, they are dealing with much larger groups of children where innocent actions can rapidly escalate into dangerous ones. A simple example might be allowing children to climb tree. As a parent, she has no problem with her own children climbing trees, as long as she knew the trees is safe and she is around to keep an eye on things. However, she wouldn’t let a class of infant children do the same because the situation would be far less manageable, with countless variables to consider. It is not always easy to know what constitutes a duty, but if courts engage in sensible dialogue the levels very quickly emerge. However, the proximity doctrine has given rise to problems as it leaves much discretion to judges to determine whether a duty should exist in a given situation. The test was criticized in a number of cases, such as Governors of the Peabody Donation Fund v. Sir Lindsay Parkinson & Co Ltd,83 Leigh and Sillavan Ltd v. Aliakmon Shipping Co Ltd,84 Curran v. Northern Ireland Co-ownership Housing Association Ltd,85 and, Yuen Kun Yeu v. Attorney General of Hong Kong.86

84 Leigh and Sillavan Ltd v. Aliakmon Shipping Co Ltd, 1 AC, 785, 1986.
1.2.4. The three stage test

In *Caparo Industries Plc v. Dickman*\(^8^7\) a three part test was established in order to determine whether a duty of care exists.

The first is foresight, which means a reasonable contemplation of harm;

The next is proximity, which means a close relationship between the claimant and the defendant.

Lastly, it must be fair, just and reasonable to impose a duty and the courts must consider whether in all the circumstances it would be fair, just and reasonable that the law should impose a duty.

In general, a person is under a duty to all persons at all times to exercise reasonable care for their physical safety and the safety of their property. The test known as the *Anns test*\(^8^8\) imposed a prima facie duty of care where a sufficient relationship of proximity or neighborhood exists between the alleged wrongdoer and the person who has suffered damage, such that carelessness on the part of the former is likely to cause damage to the latter. The existence, scope and limits of a duty of care have not a single general principle. The situations guided in determining whether there was a relationship of proximity between the parties by itself. It would determine whether the particular damage suffered was the kind of damage which the defendant was under a duty to prevent and whether there were circumstances from which the court could pragmatically conclude that a duty of care existed. Where the defendant assumed or undertook responsibility towards the plaintiff in his conduct and the plaintiff relied on the defendant to exercise due skill and care in respect of such conduct, the defendant is liable for any failure to use reasonable skill and care. The principle depended on the assumption or undertaking of responsibility by the defendant towards the plaintiff, coupled with reliance by the

\(^{8^7}\) *Supra* n. 11.

\(^{8^8}\) *Supra* n. 77.
plaintiff on the exercise by the defendant of due care and skill and was wide enough to apply where the defendant had access to action and failed to exercise due care and skill in acting on that source of action. Applied to the physician, patient relationship, the physician possessed special knowledge, derived from his knowledge and art, skill and diligence in the performance of his duties in treatment process, he did for the assistance of the patient, who necessarily had to rely on the physician to exercise due skill and care in the preparation of the treatment. The physician was therefore required to use reasonable care and skill in ensuring the accuracy of any facts which either were communicated to the patient. Duty of care not only refers to the circumstances and relationships which the law recognizes as giving rise to a legal duty to take care but also for determining a duty of care it must be fair, just and reasonable to impose liability. A failure to take such care can result in the defendant being liable to pay damages to a party who is injured or suffers loss as a result of their breach of duty of care. Therefore, it is necessary for the claimant to establish that;

a. Harm is a "reasonably foreseeable" result of the defendant's conduct;

b. A relationship of "proximity" between the defendant and the claimant;

c. It is "fair, just and reasonable" to impose liability.

For example, if a property owner leaves a deep hole in her backyard with no warnings or barriers around the hole, she should be liable if her guest falls into the hole. But what if a trespasser enters the backyard at night and falls into the hole? Although the property owner was negligent in failing to guard against someone falling into the hole, it would be unfair to require the property owner to compensate the trespasser for his injury. Therefore, the law states that a property owner does not have a duty to protect a trespasser from harm. So the existence of a duty of care depends on the type of loss and different legal tests apply to different losses. The three-stage test was endorsed in Murphy v Brentwood District Council, which declared Anns to be wrongly decided. So the

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89 Supra n. 11.
Caparo test is now the test which needs to be used to establish whether a duty of care exists. Three questions will need to be asked by the courts:

1) Was the damage reasonably foreseeable? This means that the defendant must have foreseen the risk of harm to the claimant at the time he/she is alleged to have been negligent. This is an objective test: relevant is not what the defendant actually did foresee, but what a reasonable person in the circumstances of the defendant ought to have foreseen.

The claimant does not have to be individually identifiable for the defendant to be expected to reasonably foresee the risk of harming him/her. In most cases it will be sufficient if the claimant falls within a category of people to whom the risk of harm was reasonably foreseeable.

2) Was there a relationship of proximity between defendant and claimant? So there must be a sufficient relationship of proximity between the parties for the duty to be imposed. Proximity was part of both the neighbour principle in the Donoghue case and the two-part test in the Anns case and is still a major factor in determining if there is a duty of care. What will constitute proximity will vary from case to case. Legal proximity is what counts, rather than factual proximity. Questions of policy appear to influence the question whether or not the required degree of proximity exists in a given situation.

3) Is it fair, just and reasonable in all the circumstances to impose a duty of care? This condition appears to add little to the requirement of proximity, especially because policy is also considered under the proximity test. There must be a limit to liability and that no duty will be imposed unless it is just in all the circumstances. This means that the existence of the duty depends on the individual circumstances of each case.91

The proposition that each case is decided upon its own facts by the application of principle from preceding cases in the relevant hierarchy of courts is a fundamental rule to

90 Supra n. 77.
91 Murphy v. Brentwood District Council, 2 All ER, 908, 1990.
the common law doctrine of precedent. Identification of the facts, to which the statements of law relate, discovers the true principle in any case. The doctrine of precedent is an inherently unsuitable vehicle for the determination of policy because each case is decided upon its own facts. It is the big conundrum of common law negligence system.

### 1.3. Omissions

There are two types of omissions. Firstly, a person may fail to take appropriate precautions, which would be regarded as a negligent act. Secondly, it may refer to passive inaction where a person does not take any action. The general rule is that there is no duty on a person to take action in order to prevent harm befalling others. One always has a duty to refrain from taking actions that endanger the safety of others, but usually one does not have a duty to render aid or prevent harm to a person from an independent cause.\(^9\)

A common example of this limitation on duty is the lack of a duty to go to the aid of a person in peril. An expert swimmer with a boat and a rope has no duty to attempt to rescue a person who is drowning.\(^9\)

This reflects the position that no person is required to provide assistance to another except in exceptional circumstances.\(^9\) As summarized in *St. John v. Pope*\(^9\), "Professionals do not owe a duty to exercise their particular talents, knowledge, and skill on behalf of every person they encounter in the course of the day ... It is only with a physician's consent, whether express or implied, that the doctor–patient relationship comes into being."\(^9\)

On the basis of the principle of contract law, that both parties must assent to the creation...
of a relationship\textsuperscript{97}, the right of refusal has been extended to emergency situations even when no other physician is available.\textsuperscript{98} The duty of care is one component of the law of negligence. The status of the claimant in an act of negligence can result in a duty of care arising where it would not normally or prevent a duty of care existing altogether. Claims that a doctor may owe a mother a duty of care to advise against child birth, and claims that police may owe an individual involved in criminal behavior a duty of care, have been barred. Generally, no duty of care may arise in relation to pure omissions; acts which if taken would minimize or prevent harm to another individual. However, where an individual creates a dangerous situation, even if blamelessly a duty of care may arise to protect others from being harmed.

Where an individual left his car without lights on at the side of a carriageway, he owed a duty of care to other drivers, despite the road being well lit, and was thus jointly liable when another driver collided with his car.

One can put the matter in political, moral or economic terms. In political terms, it is less of an invasion of an individual's freedom for the law to require him to consider the safety of others in his actions than to impose upon him a duty to rescue or protect. A moral version of this point may be called the ‘Why pick on me?’ argument.\textsuperscript{99}

There are however certain circumstances in which an individual may be liable for omissions, where a prior special relationship exists. Such a relationship may be imposed by statute; the Occupiers' Liability Act, for example imposes a duty of care upon occupiers of land and properties to protect in as far as is reasonable others from harm. In other cases, a relationship may be inferred or imposed based on the need to protect an

\textsuperscript{97}Hurley v. Eddingfield, 59 NE 1058, 1901.
\textsuperscript{99}Stovin v. Wise, AC 923, 1996.
individual from third parties. In Stansbie v. Troman a decorator failed to secure a household he was decorating, resulting in a burglary while he was absent; it was found he owed a duty to the household owner to adequately secure the premises in his absence. An authority or service may equally owe a duty of care to individuals to protect them from harm.

1.4. Test for Determining Medical Negligence

The basic principle under which a case of medical negligence as a criminal offence as also a tort has to be evaluated has been succinctly laid down in Jacob Mathew is which the Court adopted the test laid down in Bolam in which it has been observed that 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 the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and profusely to 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. This judgment had been followed repeatedly not only in India but in other jurisdictions as well and that it is the statement of law as commonly understood today.

The classical statement of law in Bolam's case has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been invariably cited with approval before the courts in India and applied as a touchstone to test the pleas of medical negligence. In tort, it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be

100 Stansbie v. Troman, 1 All ER, 599, 1948.
101 Supra n. 10.
102 Bolam v. Friern Hospital Management Committee, (1957) 2 All ER 118 (QBD).
103 Ibid.
noted. Firstly, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used. In a case of a failed tubectomy leading to a plea of medical negligence the Court observed that;

A Doctor, in essence, needs to be inventive and has to take snap decisions especially in the course of performing surgery when some unexpected problems crop up or complication sets in. If the medical profession, as a whole, is hemmed in by threat of action, criminal and civil, the consequence will be loss to the patients. No doctor would take a risk, a justifiable risk in the circumstances of a given case, and try to save his patient from a complicated disease or in the face of an unexpected problem that confronts him during the treatment or the surgery. It is in this background that this Court has cautioned that the setting in motion of the criminal law against the medical profession should be done cautiously and on the basis of reasonably sure grounds. In criminal prosecutions or claims in tort, the burden always rests with the prosecution or the claimant. No doubt, in a given case, a doctor may be obliged to explain his conduct depending on the evidence adduced by the prosecution or by the claimant. That position does not change merely because of the caution advocated in Jacob Mathew in fixing liability for negligence, on doctors.

In C.P. Sreekumar the respondent was going on his bicycle when he was hit by a motorcycle leading to an injury to his leg. He was admitted to the Hospital, of which the appellant was the Managing Director. An X-ray of the leg revealed a hairline fracture of the neck of the right femur. The appellant, as the attending doctor, chose a conservative line of treatment and put the respondent's leg in a plaster of paris bandage known as

106 C.P. Sreekumar (Dr.), MS (Ortho) v. S. Ramanujam, (2009) 7 SCC 130.
derotation boots' in order to immobilize the leg. On the insistence of the respondent that he be released to recuperate at home, he was taken for another X-ray a prelude to his discharge wherein it was found that the simple hairline fracture Garden type I had developed to a more serious Garden type III fracture. Three physicians thereupon decided that an operation be performed on the injured leg. On considering the various options available, decided to perform a hemiarthroplasty instead of going in for the internal fixation procedure. The respondent consented to the choice of the surgery after the various options had been explained to him. The surgery was performed on the next day. The respondent remained admitted as an indoor patient, during which post operative treatment and monitoring was done by the appellant and it was observed that a superficial infection had set in. The sutures were actually removed. The respondent was thereafter made to undergo physiotherapy and was finally discharged. The respondent appeared in the hospital and his condition was reviewed and he was instructed to go in for physiotherapy on a daily basis and to return for a subsequent review two weeks later but he neglected the advice. It is the case of the respondent that on account of lingering pain, he had consulted various doctors. The respondent sent a notice alleging negligence and deficiency in service as the simple fracture had got displaced to a more complicated one, on account of mishandling as in the choice and the manner of the surgery and calling for compensation. The appellant in his reply denied any negligence in the surgery and further pointed out that the displacement of the fracture had come about on account of natural causes i.e. a muscular spasm and that respondent after being informed about the various lines of treatment available had consented to the hemiarthroplasty.

The respondent filed a complaint before the State Commission alleging that his consent had not been taken for the hemiarthroplasty and that this procedure was not justified as the bone was in good condition. The appellant in his reply denied the allegations and prayed for the dismissal of the complaint. The Commission in its order noted that the respondent had suffered only a hairline fracture for which he had been admitted in the hospital and had been immobilized by being put in a plaster with a suggestion of six weeks bed rest so that the fracture could heal on its own, and as such there was no
occasion for the respondent to be taken for another X-ray as there was absolutely no complaint from him and it was at that stage that it was discovered that the simple hairline fracture had developed into a displaced Garden type III fracture within 2 days of the X-ray.

The Commission accordingly opined that the fact that only a few days after the hemiarthroplasty, the respondent had developed an infection clearly showed negligence at the hands of the attending doctors with the result that he had perforce to undergo a total hip replacement. In conclusion, the Commission observed: It is thus clear that:

(i) a hairline fracture developed into displaced fracture due to wrong handling in the opposite party's hospital;
(ii) the opposite party performed a Hemi-arthroplasty on a young patient of 42 years without consideration open reduction and internal fixation and against established medical practices;
(iii) the post-operative infection was not properly conducted with the result that prosthesis got loosened within a period of two months. There is thus a clear case of negligence and deficiency in service rendered by the opposite party.

The appellant pleaded that there was no warrant for the very broad proposition that the only procedure in the given circumstances to be performed on a 42 year old patient was internal fixation and that hemiarthroplasty had to be completely ruled out unless the patient was beyond 60 years of age. The basic issues arise in the present case is even assuming that some radical procedure was necessary, whether hemiarthroplasty was the appropriate one in the light of the fact that the respondent was at the relevant time 42 years of age. One of the primary arguments raised by the respondent in this case is that the appellant did not have the basic skill to carry out a hemiarthroplasty or an internal fixation and for that reason was not competent to perform the procedure.

The question as to whether hemiarthroplasty or internal fixation was the proper procedure in the background that the respondent was 42 years of age at the relevant time has been
hotly debated. It is the case of the appellant that on evaluation of the respondent's condition he had thought it fit to carry out a hemiarthroplasty whereas it is the case of the respondent that as per the various text books which have been placed on record, this procedure was invariably carried out on a patient who was 60 years of age or above and hemiarthroplasty was thus not the favoured option for him. Through several passages from various text books, it did appear that ordinarily in the case of a patient of less 60 years of age, hemiarthroplasty is not the preferred option and internal fixation involving the use of a clamp with screws was the more acceptable one. In a Prospective Review it has been pointed out that the choice between the internal fixation and immediate prosthetic replacement is often difficult to make and no full proof criteria exists for assessing which of the two procedures is the proper one in the facts of the particular case. Following the Court held that:

Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. The definition of negligence … referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three duty, breach and resulting damage. Negligence in the context of the medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. It
would, thus, be seen that the appellant's decision in choosing hemiarthroplasty with respect to a patient of 42 years of age was not as palpably erroneous or unacceptable as to dub it as a case of professional negligence.

A doctor does not need special skill to disclose the risks but rather, communicating skill, to enable the patient to apprehend his situation. Information must be given to the patient in a way that it can be digested rationally. The High Court concluded that, with regard to negligence, the scope of a doctor's duty of disclosure is:

“… to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of a particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it. This is subject to therapeutic privilege.”

In Penney108, three women developed cervical cancer, although cyto-screeners had previously reported their cervical smears as being negative. In preferring the evidence provided by experts for the plaintiff, the judge said he did not consider the evidence provided by the defendant experts as standing up to logical analysis because:

“[t]here were admitted abnormalities which, to put it most favorably to the cytoscreener, he could not positively have said they were not pre-cancerous … [Having] regard to the potentially disastrous consequences of a mistaken identification, a reasonably competent cyto-screener would have classified the smear as borderline.”

This decision was upheld in the Court of Appeal and, in giving judgment, Lord Woolf said:

107 Rogers v. Whitaker, 175 CLR, 1997
“In resolving conflicts of expert evidence, the judge remains the judge; he is not obliged to accept evidence simply because it comes from an illustrious source; he can take account of demonstrated partisanship and lack of objectivity.”

In *Pearce*¹¹⁰, the issue before the court was whether or not a doctor ought to have informed a pregnant woman at 42 weeks of gestation of the additional risk of stillbirth which was inherent in allowing the pregnancy to continue, thus enabling her to make a fully informed choice. Lord Woolf, in the Court of Appeal, said:

“[if] there is a significant risk which would affect the judgment of a reasonable patient, then in the normal case it is the responsibility of the doctor to inform that patient of that significant risk, if the information is needed so that the patient can determine for himself or herself as to the course he or she should adopt.”

In law, the standard of care in medical litigation is determined by the *Bolam*¹¹¹ test. A practitioner does not breach the standard if the practice in question is supported by a responsible body of similar medical peers. The court has applied the *Bolam*¹¹² test to a wide range of medical issues, including diagnosis, treatment, information disclosure and ethics in medicine. The principal criticism of the *Bolam*¹¹³ test is that it has extended beyond its intended limits, and allows the standard in law to be set subjectively by doctors. The case of *Bolitho*¹¹⁴ imposes a requirement for an explanation of the ‘logical basis’ underlying the standard of care that is proclaimed. The effect of *Bolitho*¹¹⁵ is that the court will enquire more closely into the justification of a defendant doctor’s practice, based on a logical analysis of why such an opinion was formed, as well as a risk analysis against competing options.

In medical litigation, the test for the standard of care in law expected of doctors is based

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¹⁰⁹ *Id.*
¹¹¹ *Supra* n.102.
¹¹² *Id.*
¹¹³ *Supra* n.102.
¹¹⁴ *Supra* n.70.
¹¹⁵ *Id.*
on the principle enunciated in *Bolam*\(^{116}\). Put at its simplest, the test is that a medical practitioner does not fail to reach the standard of care if a responsible body of similar medical peers supports the action in question. The judgment in *Bolitho*\(^{117}\), however, suggests a judicial move at the highest level to shift the balance from an excessive reliance on medical testimony supporting a defendant doctor to a more enquiring approach to be taken by the court. In order to reach its own conclusion on the reasonableness of clinical conduct, the court will arbitrate on the standard in each case. This would operate within the framework of normative values held by society. Patient empowerment is a strong theme in the new health service. This is likely to act as a conjunctive force in shifting the traditional ‘accepted practice’ approach to one whereby the standard of care is set by the court, on the basis of ‘expected practice’. This would be determined by evaluating the reasonableness of competing options. *Bolam*’s\(^{118}\) test has been approved by full bench of the Supreme Court in *Jacob Mathew*’s case in these words:

> The water of *Bolam* test has ever since flown and passed under several bridges, having been cited and dealt with in several judicial pronouncements, one after the other and has continued to be well received by every shore it has touched as neat, clean and a well condensed one.\(^{119}\)

The classical statement of law in *Bolam* case has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been invariably cited with approval before courts in India and applied to as touchstone to test the pleas of medical negligence. In tort, it is enough for the defendant to show that the standard of care and skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be

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\(^{116}\) *Supra* n.102.

\(^{117}\) *Supra* n.70.

\(^{118}\) *Supra* n. 102.

\(^{119}\) *Supra* n. 10, para 20.
noted. First, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used.

In *Bolitho v. City and Hackney Health Authority*,\(^\text{120}\) a two year old child, suffered catastrophic brain damage as a result of cardiac arrest due to respiratory failure. The senior pediatric registrar did not attend the child, as she ascribed to a school of thought that medical intervention, under those particular circumstances, would have made no difference to the end result. Liability was denied on the ground that even if she had attended, she would not have done anything that would have materially affected the outcome. This view was supported by an impressive and responsible body of medical opinion. Lord Wilkinson observed;

> The Court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant’s treatment or diagnosis accorded with sound medical practice. The use of these adjectives – responsible, reasonable and respectable – all show that the Court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving the weighing of risks against benefits, the Judge before accepting a body of opinion as being responsible, reasonable and respectable, will need to be satisfied that in forming their views the experts have directed their minds to the question of comparative risks and benefits, and have reached a defensible conclusion on the matter.

Lord Browne-Wilkinson speaks of cases and emphasizes later in his judgment that it will ‘very seldom’ be right for a judge to reach a conclusion that views genuinely held by

\(^{120}\) (1997) 4 All ER 771 (HL).
competent experts are unreasonable. On the facts of the claim before him he concluded that there was no basis for dismissing the defendants’ expert evidence as illogical. There were sound reasons not to intubate. However, the case laid down that it is not enough for the doctor charged with negligence to prove that he acted in accord with the approved practice to clear him. The practice he followed must has a logic basis so as to be responsible, reasonable and respectable. Thus even though there exists a body of professional opinion sanctioning the defendant’s conduct, the defendant can still be held negligent if the judge is not satisfied that the opinion is reasonable or responsible. Ultimately the courts, and only the courts, are the arbiters of what constitute reasonable care. doctors cannot be judges in their own cause. This is likely to shift the Bolam’s “accepted practice” approach to one whereby the standard of care is set by the court on the basis of “expected practice.”

Recently Justice S.B.Sinha in Malay Kumar Ganguly v. Dr. Sukumar Mukherjee121 case has preferred Bolitho test to Bolam test. The Supreme Court redefined medical negligence saying that the quality of care to be expected of a medical establishment should be in tune with and directly proportional to its reputation. The Court extended the ambit of medical negligence cases to include overdose of medicines, not informing patients about the side effects of drugs, not taking extra care in case of diseases having high mortality rate and hospitals not providing fundamental amenities to the patient. The decision also says that the court should take into account patient’s legitimate expectations from the hospital or the concerned specialist doctor.

In this case the patient, a lady aged about 36 years, developed fever along with skin rashes. A doctor was contacted, who after examination of the patient assured of a quick recovery and advised her to take rest but did not prescribe any medicine. As the skin rashes reappeared more aggressively, the doctor was again contacted who diagnosed that she was suffering from Anglo- Neurotic Oedema with allergic vasculitis and prescribed long acting steroid, depomedrol injection 80 mg twice daily for three days and wysolone which is also a steroid having the composition of Methyl predinosolone. As the condition

121 (2009) 9 SCC 221.
of the patient deteriorated rapidly from bad to worse despite the administration of the said medicines, she was admitted to the hospital wherein it was found by the attending doctors that the patient has been suffering from Toxic Epidermal Necrolysis (TEN). Doctors in the hospital prescribed a quick acting steroid prednisolone at 40 mg three times daily. The condition of the patient continued to deteriorate further. She was shifted to Breach Candy Hospital, Mumbai wherein she breathed her last after 10 days. The cause of the death was found to be septicemia which happened as a result of profound immuno-suppression, caused by over use of steroid and lack of supportive therapy and care on the part of attending doctors.

Complainant, the husband of the deceased, apart from filing criminal case and lodging a complaint in the West Bengal Medical Council, filed a complaint against the doctors and hospital in the National Consumer Dispute Redressal Commission (NCDRC) claiming a total compensation of more that Rs. 77 crores. The NCDRC dismissed the complaint. Aggrieved complainant came in appeal to the Supreme Court.

He pleaded that Doctors from the very beginning should have referred the deceased to a Dermatologist as she had skin rashes all over her body. Doctors had made a wrong diagnosis of the deceased’s illness and prescribing a long acting corticosteroid depomedrol injection at dose of 80 mg twice daily was wrong which led to her death. He also asserted that no supportive therapy which is imperative in TEN cases was given in the hospital. Doctor’s on the other hand, alleged that there had been no negligence or deficiency in service on their part as they prescribed medicines as per the treatment protocol noted in the text books.

After a protected trial and hearing and on consideration of the evidence and material produced on record, the Supreme Court decided that doctors and hospital were negligent in treating the patient. The court found that there is cleavage of opinion on the medical protocol for treating TEN patients. The cleavage of opinion is between pro-steroid and anti-steroid group. The court, in view of difference of opinion amongst experts, proceed on the assumption that steroid can be administered to the TEN patients. However, treatment of the patient was not found to be in accordance with the medical protocol of
pro-steroid group. The treatment line followed by the doctor in administering 80 mg of Depomedrol injection twice daily is not supported by any school of though. Those who support steroid for TEN treatment do not recommend long acting steroid which Depomedrol is. The proper dose as per the manufacturer of Depomedrol is 40-120 mg once in 1-4 week interval – 80 mg twice daily is highly excessive.

The court is not bound to hold that a doctor escape liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that his treatment or diagnosis accorded with sound medical practice. The court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. The judge before accepting a body of opinion as being responsible, reasonable and respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.

It was observed that the law on medical negligence also has to keep up with the advances in the medical science as to treatment as also diagnostics. Doctors increasingly must engage with patient during treatment especially when the line of treatment is a contested one and hazards are involved. Standard of care in such cases will involve duty to disclose to patients about the risks of serious side effects or about alternative treatment. The standard of duty to care in medical services depends on the position and stature of the doctors concerned as also the hospital. The premium stature of services raises a legitimate expectation. If representation is made by a doctor that he is a specialist and ultimately it turns out that he is not, deficiency in medical services would be presumed.

The court found the doctors to be negligent and deficient in providing medical services as:

(1) Patient had rashes all over her body, the doctor should have referred her to a dermatologist.

(2) Doctor wrongly diagnosed the disease as vasculitis.
(3) The doctor prescribed “Depomedrol” 80 mg twice a day for three days which is certainly a higher dose in case of a TEN patient and the maximum recommended usage by the drug manufacturer has also been exceeded. This is a wrongful act on his part. The immediate adverse effect of overuse of this steroid is immunosuppression and chance of infection.

(4) According to general practice, long acting steroids are not advisable in any clinical condition. Instead of prescribing a quick acting steroid, the prescription of a long acting steroid without foreseeing its implications is an act of negligence on their part without exercising any care or caution.

(5) After prescribing a steroid, the effect of immunosuppression caused due to it, ought to have been foreseen. The doctors fail to take notice of said consequences.

(6) The doctors in hospital, after taking over the treatment of the patient did not take any remedial measure against the excessive amount of Depomedrol that was already stuck in the patient’s body. On the other hand, they prescribed an excessive dose of quick acting steroid.

(7) Aggressive supportive therapy that is necessary for TEN patients was not provided in the hospital.

(8) The hospital is liable to prevent nosocomial infections specially in the cases where the patient has high risk of infection due to the nature of the disease suffered or immunosuppression caused due to use of steroids.

In the opinion of Court for the death of the patient although doctors and the hospital were negligent, it cannot be said that they should be held guilty for criminal negligence. For an act to amount to criminal negligence, the degree of negligence must be of a gross or a very high degree. A negligence which is not of such a high degree may provide ground for action in civil law but cannot form the basis of prosecution.

The court remitted the case back to the NCDRC for the purpose of determination of quantum of compensation. NCDRC finally awarded a compensation of Rs. 1,55,58,750 to be paid by the doctors and the hospital.
In *V. Kishan Rao v. Nikhil Super Speciality Hospital*\(^{122}\) the Supreme Court expressed the opinion that *Bolam test* needs to be reconsidered in India in view of Article 21, which guarantees right to medical treatment and care. However, the Court expressed its inability because of the binding precedent of *Jacob Mathew*,\(^{123}\) which approved the test.

In *Kusum Sharma v. Batra Hospital and Medical Research Centre*,\(^{124}\) the apex court reiterated the legal position after taking survey of catena of case law. In the context of issue pertaining to criminal liability of a medical practitioner, Hon’ble Mr. Justice Dalveer Bhandari speaking for the Bench, laid down that the prosecution of a medical practitioner would be liable to be quashed if the evidence on record does not project substratum enough to infer gross or excessive degree of negligence on his/her part.

In this case appellant’s husband was admitted to the respondent hospital. He was diagnosed to be having tumor in the left adrenal which was suspected to be malignant. Surgery was performed by adopting anterior approach and left adrenal was removed. During the surgery, the body of the pancreas was damaged which was treated and a drain was fixed to drain out the fluids. He was discharged from the hospital with an advice to follow up and for change of the dressing. He did not visit the respondent hospital for follow up. Instead, he took treatment from other hospitals. After few months, he died on account of pyogenic meningitis. After his death, appellant filed a complaint before the National Commission claiming compensation attributing medical negligence in the treatment by the doctors at respondent hospital. Her main plea was that the anterior approach adopted at the time of first surgery was not the correct approach, surgery should have been done by adopting ‘posterior’ approach for removal of left adrenal tumor. National commission found no merit in the claim of the appellant taking into consideration the medical literature and evidence of eminent doctors of AIIMS confirming adoption of ‘anterior’ approach in view of inherent advantages of the approach. Against that order the appellant came in appeal to the Supreme Court.

\(^{122}\) (2010) 5 SCC 513.
\(^{123}\) Supra n. 10.
\(^{124}\) (2010) 3 SCC 480.
Dismissing the appeal, the court held that in the instant case, the doctors who performed the surgery had reasonable degree of skill and knowledge and they in good faith and within medical bounds adopted the procedure which in their opinion was in the best interest of patient. Doctors could not be held to be negligent where no cogent evidence to prove medical negligence was produced by the appellant. The medical texts speak of both the approaches for adrenalectomy as adopted in the present case. Nowhere has the appellant been able to support her contention that posterior approach was the only possible and proper approach and respondent was negligent in adopting the anterior approach.\(^\text{125}\)

In practical terms, the court would scrutinize more intensely the basis on which defendant doctors proclaim the standard of care. There would be a requirement to justify this on a ‘logical basis’. The court would look for ‘logical analyses, and the opinion expressed would have to be coherent, reasoned and evidence based. The court would also apply a ‘risk analysis’ approach by seeking justification of the medical decision taken against competing alternatives. The emergence of independent guidance on good practice would enable the court to utilize the Bolitho principle more proactively in setting the expected standard of care required of doctors, in cases of medical litigation. In other words, it may no longer be sufficient for a practitioner's actions to be Bolam-defensible. The court would seek to determine whether such action is Bolitho-justifiable. The traditional Bolam test is unlikely to survive in its basic form. Medical practitioners should recognize that the time has come to say ‘bye-bye to Bolam’\(^\text{126}\), and to take account of the new requirements created by Bolitho.\(^\text{127}\)

**1.5. Error of judgment**

Error of judgment on the part of a doctor (e.g. wrongful diagnosis, wrong treatment) would tantamount to negligence if it is an error which would not have been made by a

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\(^{125}\) *Supra* n 5.


reasonably competent professional medical man acting with ordinary care. Very often, in a claim for compensation arising out of medical negligence, a plea is taken that it is a case of bona fide mistake. This may be excusable under certain circumstances but a mistake which would tantamount to negligence will not be pardoned.

In the case of Whitehouse v. Jordan\textsuperscript{128} an obstetrician had pulled too hard in a trial of forceps delivery and had thereby caused the plaintiff’s head to become wedged with consequent asphyxia and brain damage. The House of Lords held that the obstetrician was guilty of negligence. The court observed:

The true position is that an error of judgment may or may not be negligent; it depends on the nature of the error. If it is the one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant holds himself out as having and acting with ordinary care then it is negligence. If on the other hand, it is an error that such a man, acting with ordinary care might have made then it is not negligence.

In M/S Spring Meadows Hospital v. Harjot Ahluwalia\textsuperscript{129} the Supreme Court observed that gross medical mistake would always result in a finding of negligence. Use of wrong drug or wrong gas during the course of anesthetic will frequently lead to the imposition of liability and in some situations even the principle of \textit{res ipsa loquitur} can be applied. Even delegation of responsibility to another may amount to negligence in certain circumstances. A consultant can be negligent where he delegates the responsibility to his junior with the knowledge that the junior was incapable of performing his duties properly.

In Achutrao Haribhau Khodwa v. State of Maharashtra\textsuperscript{130} a mop was left inside the lady patient’s abdomen during an operation. Peritonitis developed which led to a second surgery being performed on her, but she could not survive. Liability for negligence was

\textsuperscript{128} (1981) 1 ALL ER 267.
\textsuperscript{129} AIR 1998 SC 1801.
\textsuperscript{130} AIR 1996 SC 2377.
fastened on the surgeon because no valid explanation was forthcoming for the mop having been left inside the abdomen of the lady.

In *Laxman Balkrishna Joshi’s*\(^{131}\) case the death of the patient was caused due to shock resulting from reduction of the fracture attempted by the doctor without taking the elementary precaution of giving anaesthesia to the patient. The doctor was held guilty of negligence and liable to pay damages.

In *Vinitha Ashok v. Lakshmi Hospital*\(^ {132}\) removal of pregnancy was done without ultrasonography and uterus of the patient had to be removed. There was expert evidence to indicate that ultrasonography would not have established ectopic pregnancy but some text books indicated otherwise. The general practice in the area in which the doctor practiced was not to have ultrasonography done. Therefore no negligence was attributed on this ground even if two views could be possible.

In *Dr. P.N. Rao v. G. Jayaprakasu*\(^ {133}\) a very promising young boy of 17 was admitted in a government hospital for removal of tonsils. As a result of the negligence in the administration of anaesthesia during the operation, the patient became victim of cerebral anoxia making him dependant on his parents. The anesthetist, the surgeon and the government were all held liable for damages to the plaintiff.

When an injection meant for intramuscular use was administered as an injection intravenous in a government hospital resulting in death of the patient, the government was held liable in public law for damages under Article 226 of the constitution\(^ {134}\).

In *Nizam’s Institute of Medical Sciences v. Prasanth S. Dhananka*\(^ {135}\), the complainant who was then an engineering student suffered from recurring fever. The X ray examination revealed a tumour in left hemithorax with erosion of ribs and vertebra. Even then without having MRI or Myelography done, cardiothoracic surgeon excised the tumour and found vertebral body eroded. Operation resulted in acute paraplegia of the

\(^{131}\) *Supra* n. 24.
\(^{132}\) *AIR* 2001 SC 3914.
\(^{133}\) *AIR* 1990 AP 207.
\(^{135}\) (2009) 6 SCC 1.
complainant. MRI or Myelography at the pre-operation stage would have shown necessity of a neurosurgeon at the time of operation and the paraplegia perhaps avoided. Consent was not taken for removal of tumour but only for excision biopsy. The hospital and the surgeon were held liable for negligence.

Thus, a doctor who is charged with negligence can absolve himself from liability if he can prove that he acted in accordance with the general and approved practice. He will be held liable only if the judgment is so palpably wrong as to imply an absence of reasonable skill and care on his part.\(^{136}\)

### 1.6. Consent: Disclosure of Information

Patients may waive their rights to receive information. This should be a knowledgeable and informed waiver, i.e. patients should be made aware that they have a right to receive the information, to designate a surrogate to receive the information, or to be informed at a later date. Consent in the context of a doctor-patient relationship, means the grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure.\(^{137}\) Informed consent is the process by which a fully informed patient can participate in choices about her health care. It originates from the legal and ethical right the patient has to direct what happens to her body and from the ethical duty of the physician to involve the patient in her health care.

The patient has a choice to treatment; this choice isn’t indicated to the results which come from the treatment. The patient has to know what occurs to her body and it forms the ethical duty of the physician to involve the patient in her health care. It means that a patient should be aware of what will happen to his health by taking treatment. Information which physician must inform to his patients originates from the legal and ethical right.

It is well known that the patient must give valid consent to medical treatment; and it is his prerogative to refuse treatment even if the said treatment will save his or her life. In

\(^{136}\) *Supra* n. 5.

\(^{137}\) *Samira Kohli v. Dr.Prabha Manchanda*, Appeal (civil) 1949 of 2004.
western law, the earliest expression of this fundamental principle, based on autonomy, is found in the Nuremberg Code of 1947. The Nuremberg Code was adopted immediately after World War II in response to medical and experimental atrocities committed by the German Nazi regime.\textsuperscript{138} The code makes it mandatory to obtain voluntary and informed consent of human subjects. Similarly, the Declaration of Helsinki adopted by the World Medical Association in 1964 emphasizes the importance of obtaining freely given informed consent for medical research by adequately informing the subjects of the aims, methods, anticipated benefits, potential hazards, and discomforts that the study may entail.\textsuperscript{139} Several international conventions and declarations have similarly ratified the importance of obtaining consent from patients before testing and treatment. The duty to obtain informed consent, the duty to warn, and fiduciary duty all relate to physician’s duty to provide patients with necessary and accurate information during all phases of a physician-patient relationship. The duty to obtain informed consent arises prior to undertaking a diagnostic or treatment procedure. One component of informed consent, the duty to disclose the known material risks of proposed procedures, could fairly be categorized as a duty to warn. There is general consensus on the importance of informed consent. Most people have the reasonable expectation that they be treated with respect as autonomous individuals. They also expect that they have the right to make decisions about what will and will not be done to their persons and about what personal information they will share with others. It is a moral obligation of medical professionals to disclose the necessary information to their patients, though the nature and extent of the disclosure and the legal obligation varies from one jurisdiction to another and from one country to another. A legally valid consent requires the patient to be provided with adequate information by the physician about the proposed course of treatment, its probable complications, possible alternatives and their consequences and so on.\textsuperscript{140}

In common law, informed consent is the process by which a fully informed patient can participate in choices about her health care. Every human being of adult years and sound

\textsuperscript{138}Nuremberg Code 1947.  
\textsuperscript{139}Declaration of Helsinki 1964.  
\textsuperscript{140}Supra n5.
mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages.\textsuperscript{141} A man cannot be said to be truly ‘willing’ unless he is in a position to choose freely, and freedom of choice predicates, not only full knowledge of the circumstances on which the exercise of choice is conditioned, so that he may be able to choose wisely, but the absence from his mind of any feeling of constraint so that nothing shall interfere with the freedom of his will.\textsuperscript{142} It is generally accepted that complete informed consent includes a discussion of the following elements:

1. the nature of the decision and procedure
2. reasonable alternatives to the proposed intervention
3. the relevant risks, benefits, and uncertainties related to each alternative
4. assessment of patient understanding
5. the acceptance of the intervention by the patient\textsuperscript{143}

The elements of consent are defined with reference to the patient and a consent is considered to be valid and ‘real’ when

(i) the patient gives it voluntarily without any coercion;
(ii) the patient has the capacity and competence to give consent; and
(iii) the patient has the minimum of adequate level of information about the nature of the procedure to which he is consenting to. The capacity to give valid consent is an essential element of informed Consent.\textsuperscript{144}

The ethical dimension of informed consent encourages respect for individual autonomy in medical decision-making. There are however conditions that substantially limit autonomy and therefore also autonomous choice. People with a learning disability or a mental or physical illness may be temporarily incapacitated to make autonomous choices due to their condition. In these cases the concepts of capacity and competence become

\begin{itemize}
\item \textsuperscript{141} Schloendorff v. Society of New York Hospital, 105 N E 92 N Y 1914.
\item \textsuperscript{142} Bowater v. Rowley Regis Corporation, [1944] 1 KB 476.
\item \textsuperscript{143} Salgo vs. Leland Stanford [154 Cal. App. 2d.560 (1957)]
\item \textsuperscript{144} Samira Kohli v. Dr.Prabha Manchanda, Appeal (civil) 1949 of 2004.
\end{itemize}
paramount in determining the extent to which a person's autonomy is restricted and whether that person can give a valid consent. Competence is a legal term, and courts decide on the competence of a person based on the inputs provided to it by the doctors who give an opinion on the capacity of the patient. The disability should materially incapacitate the person to comprehend facts and make independent decisions. “As a general rule, medical treatment, even of a minor nature, should not proceed unless the doctor has first obtained the patient’s consent. This consent may be expressed or it may by implied, as it is when the patient, present himself to the doctor for examination and acquiesces in the suggested routine. The principle of requiring consent applies in the overwhelming majority of cases, but there are certain circumstances in which a doctor may be entitled to proceed without this consent—firstly, when the patient’s balance of mind is disturbed, secondly, when the patient is incapable of giving consent by reason of unconsciousness; and, finally when the patient is a minor.”

In order for the patient's consent to be valid, he must be considered competent to make the decision at hand and his consent must be voluntary. It is easy for coercive situations to arise in medicine. Patients often feel powerless and vulnerable. To encourage voluntariness, the physician can make clear to the patient that he is participating in a decision, not merely signing a form. With this understanding, the informed consent process should be seen as an invitation to him to participate in his health care decisions. The physician is also generally obligated to provide a recommendation and share her reasoning process with the patient. Comprehension on the part of the patient is equally as important as the information provided. Consequently, the discussion should be carried on in layperson's terms and the patient's understanding should be assessed along the way.

When a surgeon or medical man advances a plea that the patient did not give his consent for the surgery or the course of treatment advised by him, the burden is on him to prove that the non-administration of the treatment was on account of the refusal of the patient to give consent thereto. This is especially so in a case where the patient is not alive to give evidence. Consent is implicit in the case of a patient who submits to the doctor and the

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absence of consent must be made out by the person alleging it. “In most instances, the consent of a patient is implied.”

The informed consent process allows the patient or his legal guardian to participate in and retain autonomy over the medical service received. The treatment of a patient without his or her consent has been viewed as battery and can invoke legal action. Litigation involving consent issues has often concerned the nature and extent of information that is provided to a patient in the course of obtaining authorization for treatment. The important issue that must be addressed in a discussion of informed consent is which procedures require it. A good rule of thumb is that any medical procedure or a diagnostic procedure with intravenous injection should have consent. Much has been written in the medical literature on why informed consent is so important and what it is in theory and in practice. A discussion about the proposed procedure should proceed with language that the patient can understand and start with the results of pertinent diagnostic results leading to the decision to offer procedure. The medical professionals should make particular mention of the purpose, probable outcome and likely benefits of the medical procedure.

Informed consent is fundamental to modern medical activities, but there is debate over what constitutes reasonable practice in various medical activities contexts. Practically, a few consent forms described procedures using plain language, documented relevant risks or provided information about alternative treatment options in Iran. The provision of appropriate information is an issue of medical responsibility and contrasted their findings unfavorably with the information typically received by patients in other settings. Informed consent may be oral or documentary.

The relationship between a medical professional and his patient is a contract by parties competent to contract giving rise to contractual obligations. As per the definition of consent given in section 13 of Indian Contract Act, 1872, When two or more persons agree upon the same thing in the same sense they are said to consent. This Act, however also provides under Section 11 that only those persons who are of and above 18 years of age are competent to enter into a contract. In accordance with the Indian Majority Act Parties are generally competent where;

(i) If they have attained the age of 18,

(ii) Are of sound mind, and

(iii) Are not disqualified by any law to which they are subject to.

Under section 92 of Indian Penal Code treating without consent of patient is permissible if patient is unconscious, mentally ill or gravely sick. When the time required for disclosure would create a substantial risk of harm to the patient or third parties, full disclosure requirements may not apply. It is implied that the procedure and surgery is done to save the life or limb of the patient. If possible, surrogate and proxy consent should be taken.

The consent obtained after getting the relevant information will have its own parameter of operation to render protection to the medical practitioner. If the doctor goes beyond these parameters, he would be treating the patient at his risk, as it is deemed that there is no consent for such treatment at all. A doctor who went ahead in treating a patient, to protect the patient's own interest, was held liable if he was operating without\textsuperscript{151} consent. Where a surgeon is consulted by a patient and consent of the patient is taken for diagnostic procedure/surgery, such consent can't be considered as authorization or permission to perform therapeutic surgery either conservative or radical.\textsuperscript{152}

\textsuperscript{151} Sidaway v. Board of Governors of the Bethlem Royal Hospital, [1985] 1 AC 871, HL.
\textsuperscript{152} Samera Kohli v. Dr. Prabha Manchanda, 2008;(1) SCALE 442.
There is some exception to the rule, that an unauthorized procedure may be justified if the patient’s medical condition brooks no delay and warrants immediate action without waiting for the patient to regain consciousness and take a decision for himself. The consent factor may be important very often in cases of selective operations, which may not be imminently necessary to save the patient’s life. But there can be instances where a surgeon is not expected to say that ‘I did not operate on him because, I did not get his consent’. Such cases very often include emergency operations where a doctor cannot wait for the consent of his patient or where the patient is not in a fit state of mind to give or not to give a conscious answer regarding consent. Even if he is in a fit condition to give a voluntary answer, the surgeon has a duty to inform him of the dangers ahead of the risks involved by going without an operation at the earliest time possible.\textsuperscript{153}

In \textit{Dr. T.T. Thomas vs. Elisa}\textsuperscript{154}, the patient was admitted into the hospital on March 11, 1974. Upon admission, the patient was diagnosed as a case of perforated appendix with peritonitis requiring an operation. But, unfortunately no operation was done until his death on March 13, 1974. The contention of the doctor was that no surgery could be adhered to, albeit the suggestion, because the patient did not consent for the surgery. Therefore, other measures were taken to ameliorate the condition of the patient, which grew worse by the next day. Although the patient was then willing to undergo the operation, his condition did not permit it. On the other hand, the version of the respondent (i.e., the Plaintiff) was that the doctor demanded money for performing the surgery. Furthermore, the doctor was attending to some chores in an outside private nursing home to conduct operations on the other patients and that the appellant doctor came back only after the death of the patient. The two versions before the court were: 1) the plaintiff (the deceased patient's wife) said that the doctors concerned demanded a bribe, hence the operation was delayed until it proved fatal and 2) the version of denial for consent. Finally, the court delivered a verdict in favor of the plaintiffs stating that consent under such an emergent situation is not mandatory. It is interesting to note the following

\textsuperscript{153} \textit{Marshall v. Curry}, 1933 (3) DLR 260.
\textsuperscript{154} \textit{Ibid.}
observations: The consent factor may be important very often in cases of selective operations, which may not be imminently necessary to save the patient's life. But there can be instances where a surgeon is not expected to say that ‘I did not operate on him because, I did not get his consent’. Such cases very often include emergency operations where a doctor cannot wait for the consent of his patient or where the patient is not in a fit state of mind to give or not to give a conscious answer regarding consent. Even if he is in a fit condition to give a voluntary answer, the surgeon has a duty to inform him of the dangers ahead of the risks involved by going without an operation at the earliest time possible. When a surgeon or medical man advances a plea that the patient did not give his consent for the surgery or the course of treatment advised by him, the burden is on him to prove that the non-performance of the surgery or the non-administration of the treatment was on account of the refusal of the patient to give consent thereto. This is especially so in a case where the patient is not alive to give evidence. Consent is implicit in the case of a patient who submits to the doctor and the absence of consent must be made out by the patient alleging it.\textsuperscript{155}

In Indian law there is a stipulation in the contract law stating that consent of any party that is obtained by coercion, undue-influence, mistake, misrepresentation or fraud, will render the agreement invalid. The patient's consent should only be "presumed", rather than obtained, in emergency situations when the patient is unconscious or incompetent and no surrogate decision maker is available.

The principle of autonomy is enshrined within Article 21 of the Indian Constitution, which deals with the right to life and personal liberty. The expression personal liberty under Article 21 is of the widest amplitude and covers a wide variety of rights, including the right to live with human dignity and all that goes along with it, and any act which damages, injures, or interferes with the use of any limb or faculty of a person, either permanently or temporarily.\textsuperscript{156}

\textsuperscript{155} TT Thomas (Dr.) vs Elisa. AIR 1987 Ker. 52.
\textsuperscript{156} Maneka Gandhi v. Union of India, AIR 1978 SC 597.
The legal precedent for consent arises from the case *Schloendorff v. Society of New York Hospital* in 1914 in New York state, in which a surgeon failed to take consent for hysterectomy. Benjamin Cardoza, J. observed:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body and the surgeon who performs operation without his (patient’s) consent commits assault for which he is liable in damages.

It is a moral obligation of medical professionals to disclose the necessary information to their patients, though the nature and extent of the disclosure and the legal obligation varies from one jurisdiction to another and from one country to another. A legally valid consent requires the patient to be provided with adequate information by the physician about the proposed course of treatment, its probable complications, possible alternatives and their consequences, and so on.

Various criteria have been proposed as both legal and moral standards for adequate disclosure of information, like the reasonable doctor standard (what a reasonable doctor thinks that a patient should know), the reasonable man standard (what a reasonable man under similar circumstances would like to know), and the subjective standard (what a particular patient, rather than a hypothetical reasonable person, considers adequate information). *Natanson v. Kline*, held that it was the amount of information that a reasonable doctor would provide. *Canterbury v. Spence*, held it was that amount of information which a reasonable patient would need to make a medical decision. The court observed that;

> A risk is…material when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks, in deciding whether or not to

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157 105 NE 92 (1914).
160 (1972) 464 F 2d. 772.
forego the proposed therapy. The doctor, therefore, is required to communicate all inherent and potential hazards of the proposed treatment, the alternative to that treatment, if any, and the likely effect if the patient remained untreated. This stringent standard of disclosure was subjected to only two exceptions:

(i) Where there was a genuine emergency, e.g. the patient was unconscious; and

(ii) Where the information would be harmful to the patient, e.g. where it might cause psychological damage, or where the patient would become so emotionally distraught as to prevent a rational decision.

The English law regarding disclosure of risk follows the Bolam principle. In Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Mandsley Hospital,\textsuperscript{161} the House of Lords adopted the Bolam test and followed the reasonable doctor standard regarding the duty of disclosure of risk of proposed treatment. It was considered that full disclosure of risk according to the principles of informed consent is not an appropriate test for liability for negligence. The Canterbury doctrine was rejected as it was thought to be impractical and meaningless because it did not give sufficient value to the realities of the doctor-patient relationship. Lord Bridge, however, made it clear that it is the duty of the doctor to answer correctly and fully all the queries of the patient. He further held that remote risk of damage (referred to as risk at 1 or 2 per cent) need not be disclosed. However, if the risk of damage is substantial (referred to as 10 per cent risk), it may have to be disclosed. However, Lord Woolf, in Pearce v. United Bristol Healthcare NHS Trust,\textsuperscript{162} accepted the ‘reasonable patient test’ and the ‘doctrine of informed consent’ into the English law. Citing both Sidaway and Bolitho, it was observed that:

\textsuperscript{161} (1985) 1 All ER 643.
\textsuperscript{162} (1998) 48 BMLR 118.
‘If there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of doctor to inform the patient of the significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.

The Apex Court of Australia has also started moving away from the Bolam test and has started accepting the concept of informed consent. It observed, in Rogers v. Whitaker,\(^{163}\) that the question whether the patient has been given all relevant information to choose between undergoing and not undergoing the treatment does not depend on medical standard or practices. This is a question for the court to decide and the duty of deciding it cannot be delegated to any professional or group in the community. The Canadian courts are also following the reasonable patient approach.\(^{164}\)

It was well establish that consent which is not properly informed, is not real consent. Once the patient had been informed, in broad terms, of the nature of intended treatment/procedure and had given his consent, the patient cannot state that there was a lack of real consent.\(^{165}\)

Recently, a three judges bench of the Supreme Court of India, awarded a compensation of Rs.25,000 and waiver of surgery fees to a women whose uterus was removed by a lady obstetrician without her consent.\(^{166}\) The question before the court was whether a surgeon can legally perform one operation after taking consent for another. It was alleged that the patient was admitted to a private hospital for ‘diagnostic and operative laparoscopy but instead a ‘hysterectomy (removal of uterus) and bilateral salpingo-oopherectomy’ (removal of fallopian tubes) was performed, rendering her incapable of bearing any children in the future. Completely forbidding additional surgery without consent from the

\(^{163}\) (1992) 109 ALR 625.
patient. 167 The Court summarized the various aspects of consent in the following words:

(1) A doctor has to seek and secure the consent of the patient before commencing a ‘treatment’ (the term “treatment” includes surgery also). The consent so obtained should be real and valid, which means that: the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what he is consenting to.

(2) The ‘adequate information’ to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment or not. This means that the doctor should disclose (a) nature and procedure of the treatment and its purpose, benefits and effect; (b) alternatives if any available; (c) an outline of the substantial risks; and (d) adverse consequences of refusing treatment. But there is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment which may persuade should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.

(3) Consent given only for a diagnostic procedure, cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment

167 Supra n.5.
procedure. The fact that the unauthorized additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault and battery. The only exception to this rule is where the additional procedure though unauthorized, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorized procedure until patient regains consciousness and takes a decision.

(4) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

(5) The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in *Canterbury* but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field. It will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment.

**Conclusion**

A professional is liable both under law of contract and tort. In general a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services. Liability in contract depends on the express or implied terms agreed upon by the patient and the medical man. While tortious duties of professional man are limited to taking reasonable care, the contractual duties are generally more onerous in nature.
Indian Supreme Court in *Rajkot Municipal Corporation v. Manjul Ben Jayantilal Nakum*, (1997) 9SCC, 1997. held that if the claim depends upon proof of contract, action does not lie in tort. If the claim arises from relationship between the parties independent of the contract, an action would lie in tort at the election of the plaintiff, although he might alternatively have pleaded in contract.

Where the breach of duty alleged arises of a liability independently of the personal obligation undertaken by contract, it is tort even though it may happen to be a contract between the parties, if the duty in fact arises independently of that contract.

A contract is founded upon mutual consent and agreement. A tort is inflicted against or without consent. A contract requires privity of parties. In tort no privity between parties is needed. A tort is violation of right in rent, a right vested in some determinate person, either personally or as a member of the community, and available against the world at large, whereas a breach of a contract is an infringement to a right in personam, i.e. of a right available only against some determinate person or body. In a breach of contract, the motive for breach is immaterial while in a tort it is often taken into consideration. In a breach of contract, damages are only compensation. Where the injury is caused to a person, character or feelings and the facts disclosed improper motive or conduct which aggravates the plaintiffs injury, he may be awarded exemplary damages to punish the defendant and to deter him in future in certain cases in tort but rarely in a contract. The same act may amount to a tort and a breach of contract as well.

In the celebrated case of *Donoghue*, a manufacturer who sold a substandard ginger beer to a retailer who sold it to a customer and the customer and his friend drank and became ill. It was held that the manufacturer was under a contractual duty to the retailer and was in breach of that duty, but he also owes a duty in tort to take reasonable care not to harm the consumers.

Tort is basically the origin of common law. Indian legal system has many similarities with common law principles and thus courts in India have enough space for interpretation

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169 *Supra* n. 14.
in that line to hold a physician liable for medical negligence in those areas of medical practice where Consumer Protection Act cannot address.

Under civil law, at a point where the Consumer Protection Act ends, the law of torts takes over and protects the interests of patients. This applies even if medical professionals provide free service. In cases where the services offered by the doctor or hospital do not fall in the ambit of 'service' as defined in the consumer Protection Act, patients can take recourse to the law relating to negligence under the law of torts and successfully claim compensation. The onus is on the patient to prove that the doctor was negligent and that the injury was a consequence of the doctor's negligence. Such cases of negligence may include transfusion of blood of incorrect blood groups, leaving a mop in the patient's abdomen after operating, unsuccessful sterilization resulting in the birth of a child, removal of organs without taking consent, operating on a patient without giving anesthesia, administering wrong medicine resulting in injury, etc.

170Talha Abdul Rahman, Medical negligence and doctor's liability, Indian J Med Ethics. 2005 Apr-Jun; 2(2)