CHAPTER 4
RIGHT TO MEDICAL TREATMENT

4.1. INTRODUCTION

A patient in receipt of medical treatment is entitled to respect for his or her autonomy, physical integrity and privacy, but the entirety of such rights' protection presupposes that the patient has access to the necessary medical treatment.[1] The 58th session of the World Health Assembly in 2005 defined universal health care as providing access to key promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost.[2] According to figures, roughly two billion people lack access to essential drugs or to primary health care.[3] Millions are afflicted by infections and illnesses that are easily avoidable or treatable.[4] In the developing world many children die or grow stunted and damaged for lack of available treatments. [5] Tropical diseases receive little or no attention by the major pharmaceutical company's research departments.[6]

The discussion on various conventions and declarations in the first chapter suggests that for achieving the goal of right to healthcare, health service must be comprehensive and high in quality. But the measures put forth by declarations remain tragically unfulfilled. The goal of a comprehensive, high quality medical care that is freely available to all on the basis of medical need is difficult in the face of steadily increasing costs; therefore, the temptation is to lower one standard in favor of the other.[7]

The chapter focuses on whether a patient has a 'right' to receive medical treatment? A patient's 'right' to receive medical treatment largely depends on the availability of resources in the State and interestingly, resources are always scarce. Thus, the answer to the above stated question more or less lies within the broader

---

1 Elizabeth Wicks, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.17.
2 M. Govinda Rao, Mita Choudhury , *Health Care Financing Reforms in India*, Working Paper No: 2012-100, National Institute of Public Finance and Policy, March- 2012, p.2.
3 Pavlos Eleftheriadis, "A Right to Health Care", 40 *J.L. Med. & Ethics* 268 (2012).
4 Id.
5 Id.
6 Id.
7 Mason, McCall Smith, Laurie, *Law and Medical Ethics*, 7th edn, Oxford University Press, Oxford, (2006), pp.416-17.

issue of allocation of available scarce resources. Limited funding puts pressure on health providers and medical professionals and inevitably results in some patients being denied the medical treatment which they need. Once a patient overcomes the hurdles of scarcity of resources the law's focus turns to the quality of medical care offered to the patient. Hence, the second part of the chapter discusses the role of physician in ensuring quality care to patients.

4.2. SCARCE HEALTHCARE RESOURCES

The contribution of a health system in improving health depends, firstly, on how easily a person can access appropriate and effective health services in case of medical need. 'Access' may mean that services are available whenever and wherever the patient needs them and that the point of entry to the system is well-defined.[8] 'Access' has also been taken as synonymous with the availability of financial and health system resources in a country.[9] Access is, nonetheless, a rather complex concept and the term is often used interchangeably with coverage or utilization. The ability to use services when they are needed is associated with factors related to both service provision and service usage, i.e., to supply and demand factors[10]. On the provision side, there has to be an adequate supply of quality services that are efficacious. To what extent a person uses the services depends on many factors. Firstly, people have different expectations of their health and therefore have different perceptions of their health care needs. When need is perceived, many other factors still govern the actual use of services. Financial affordability, in terms of the costs of the services as well as the costs of accessing them, is important. However, many non-financial reasons may also be important, such as physical accessibility and cultural acceptability of the services and various forms of social exclusion and marginalization.[11]

---

8 Lu Ann Aday and Ronald Andersen, "A Framework for the Study of Access to Medical Care", *Health Services Research* (1974), p.209.

9 Id.

10 Gulliford M, Figueroa-Munoz J, Morgan M, Hughes D, Gibson B, Beech R *et al*, "What does 'access to health care' mean?" 7 *J Health Serv Res Policy* 186 (2002), pp.186-8.

11 Closing the gap in a generation: health equity through action on the social determinants of health, Final Report of the Commission on Social Determinants of Health (2008), viewed 11th Dec 2013, http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

The discussions in the first chapter makes it clear that we have a human right to health care and that would include providing life saving treatment.[12] Right to life recognized by international conventions undoubtedly offers the potential for a right to treatment at least a right to life-saving treatment and perhaps more if we accept the old maxim that life depends upon health.[13] Where the treatment is not life-saving there may either be no right to it at all, or the rights of individuals will need to be pitted against each other.[14] However, a patient is not entirely without rights- based protection. The patient is entitled to equal consideration with other patients in the same position, is entitled not to have a refusal of treatment decided upon on a discriminatory basis and to have his request for treatment assessed on the basis of individual need. However, limited public funding puts extreme pressures upon health authorities and medical professionals and inevitably results in some patients being denied the medical treatment which they need.[15]

When imposing positive obligations upon State authorities, there must be recognition of the need to balance conflicting demands upon the public purse.[16] As McBridge notes, 'although it is clear that there is a very substantial duty to protect life, it is also evident that this is not one that is to be fulfilled regardless of all other considerations'.[17] In *Osman* v *United Kingdom*[18] , the Court explicitly recognized the need to balance resources and concluded that the obligation to safeguard lives must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities.[19] This requirement of proportionality would also need to serve as a constraint upon any right to life-saving medical treatment and may have particular significance given the limits of public funding of

---

12 See, Chapter 1, Health and Human Rights.

13 *R* v *Bourne* [1939] 1 KB 687. The defendant, had performed an abortion on a girl who had been raped, the jury upheld the judge's view that an abortion could lawfully be done to prevent the mother from becoming 'a physical or mental wreck'.

14 Jonathan Herring, *Medical Law and Ethics*, 3rd edn., Oxford University Press, New York (2010), p.76.

15 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p. 17.

16 Id. p.18.

17 J McBridge, "Protecting Life: A Positive Obligation to Help", 24 *Eur Law Rev HR Survey* 43 (1999), p.52.

18 29 EHRR 245. The case concerned a failure on the part of the police to prevent a death, but the principle extends to the provision of life-saving medical treatment.

19 Id. para 116.

healthcare.[20] For example, in UK, the National Health Service Act, 2006 obligates the Secretary of State for Health to promote a comprehensive health service designed to secure improvements in the physical and mental health of the people and in the prevention, diagnosis and treatment of illness.[21] Further, the Act requires that these services must be provided free of charge unless the law expressly permits charges to be made.[22] It further specifies the types of services which it is the Secretary of State's duty to provide which includes hospital accommodation, medical, nursing, dental and ambulance services.[23] However, case laws have established that the Secretary of State's duty under this provision is subject to the need to take into account the existing financial resources. It is to be asserted here that the courts have shown great sympathy but little inclination to be dragged into such a morally difficult and emotive issue.

Resource allocation is a central part of the decision-making process in any health care system and unfortunately resources have always been finite. The allocation of health resources refers to decisions made about the distribution of limited health care funding and resources. Since the demand for health care services often exceeds supply, prioritization may become necessary. However, prioritizing patients can raise ethical dilemmas when the principle of justice is weighed against the costs and benefits of living in a complex, diverse society. Resource allocation decisions are taken at three levels: by government[24], by health authorities[25], and by medical staff[26]. It is at the final level that choices between specific patients needing treatment may have to be faced and, therefore, it is this level which most directly impact individuals. For example, when a physician has to consider the question whether a drunken driver or his accident victim be treated first, it could be argued that the drunken driver has relinquished his right to receive healthcare at the expense

---

20 J McBridge, "Protecting Life: A Positive Obligation to Help", 24 *Eur Law Rev HR Survey* 43 (1999), p.54.

21 Sec. 1(1)

22 Sec. 1(2)

23 Sec. 3

24 Political choices must be made about how much public money should be spent while deciding the healthcare budget in the light of the other competing demands upon the nation's resources and within the health budget, priorities must be set in order to determine how much money should be spent on different types of healthcare.

25 when allocating their budget to individual hospitals.

26 within hospitals when choosing how best to use the limited resources available to them. It might be necessary to choose between individual patients, perhaps in order to work out which one should be given the only available bed in an intensive care unit.

of a more innocent patient. In this case, the obvious means of choosing between these two patients in equal clinical need of the treatment is to treat the one most deserving. In the face of scarcity, resources are either explicitly or implicitly rationed. Rationing of health care limits access to beneficial health care services. The central question, then, is not whether health care is rationed, but how, by whom and to what degree. The ethical dilemma is how to balance the precepts of autonomy, beneficence, and distributive justice.

4.3. RATIONING STRATEGIES

Interestingly, in the early years rationing meant that people should have a fixed quota of resources.[27] Here the members of the society used to share the deprivation equally across society as part of a collective commitment to the national good.[28] As Emily Jackson[29] notes: 'this was conspicuously egalitarian: deprivation was to be shared equally across society as part of a collective commitment to the national good'. But this has changed over the course of time and now rationing refers to the discretionary allocation of scarce resources, with deprivation generally distributed unevenly across society.[30] Though, medical technology has advanced extensively, but providing optimum access to medical care to the whole population is impossible as it is likely to absorb the entire country's resources.[31] Therefore, prioritization has become inevitable. Hence, it is obvious that some sections of patients do have to make compromise in terms of receiving or to have access to the best possible care.

When the demand for medical treatment significantly outstrip the available resources, decisions must be made about how to distribute the limited resources, recognizing that not all needs will be satisfied immediately and some may not be satisfied at all. Decisions about distributing scarce health care resources can arise at

---

27 Emily Jackson, *Medical Law, Text, Cases and Materials*, Oxford University Press, 2nd ed.,2010, p.33.

28 Id.

29 Id.

30 Id.

31 Mark Hall, "Rationing Health Care at the Bedside", 69 *New York University Law Review* 693 (1994), at p.694.see also, Richard D Lamm, "Rationing of Health Care: Inevitable and Desirable", 140 *University of Pennsylvania Law Review* 1511 (1992), p.1152. In this article mention of a study is made which estimates that providing all the health care that could prove beneficial to each French citizen would cost five and a half times France's gross national product.

all levels, from societal choices within a national health care system (macro level) to individuals allocating immediate emergency treatment among the severely injured survivors of a motor vehicle accident or industrial accident (micro level). At the macro level, political choices have to be made about how much public money should be spent on healthcare in the light of the other competing demands upon the nation's resources and within the health budget, priorities must be set in order to determine how much money should be spent on different types of health care.[32] At the micro level, healthcare professionals decide which individuals are cared for first, which patients receive which diagnostic tests and which drugs, which patients are admitted to a hospital bed, and which patients are taken to the operating theatre. Also, at the micro level, it might be necessary to choose between individual patients, perhaps in order to work out which one should be given the only available bed in an intensive care unit.[33] Micro-level priority setting also known as bedside rationing is inevitable because of the increasing gap between the possibilities of effective medical interventions and the available resources.[34]

The Canada Health Act, for example, mandates reasonable access to medically necessary services.[35] But, the statute does not specify what those services should be, nor does it specify a mechanism for making difficult and contentious decisions with regard to scarce resources. Medical resources are finite and therefore, we need to find a fair way of distributing them.[36] Here we are exactly at the heart of what Rawls calls the 'circumstances of justice'.[37]As Elizabeth Wicks argues 'the fundamental principle underlying access to healthcare must be equality and any factors which encourage a moral assessment of the patient's previous actions or

---

32 Emily Jackson, *Medical Law, Text, Cases and Materials*, Oxford University Press, 2nd ed. (2010), p.33.

33 Id.

34 Peter A. Singer, A. M. Viens, *The Cambridge Textbook of Bioethics*, Cambridge University Press (2008), p.253.

35 See, s.3, Canada Health Act, 1985.

36 Pavlos Eleftheriadis,"A Right to Health Care", 40 *J.L. Med. & Ethics* 268(2012), p. 269. Effective health care is a matter of very complex cooperative processes, including networks of education, professional regulation, information, expertise and commerce. Such networks connect persons across the globe. One's survival may thus depend on a medicine produced in India, shipped to one's country on a Greek ship, administered in London by a Ghanaian doctor who was educated in Germany and being paid by an insurance company based in France, financed by another company based in New York.

37 J. Rawls, *A Theory of Justice*, Oxford University Press, Oxford (1999), pp.109-12.

status should be disregarded'.[38] Hence, equality of rights protection is vital. Equal distribution of healthcare resources does not mean that all resources must be divided equally between citizens. Rather, it means patients who are alike in relevant ways should be treated alike, and patients who are unlike each other should be treated differently. Equality does not tell us how to allocate scarce resources. Instead it ensures that resources are employed consistently between patients in order to avoid arbitrary and unfair distribution of resources.[39] According to Ian Kennedy[40], 'this approach to rationing might lead us to direct resources to those who are most disadvantaged by their ill health, perhaps to people with the greatest health needs'. Distributing resources as per need might appear attractively fair and simple at first sight. The concept of need is however, remarkably elastic and culturally variable.[41] According to Emily Jackson[42], 'need could only operate as a rationing criteria if we were able to construct some sort of hierarchy of needs, so that we could tell whether one patient's need was greater or less than the need of other candidates for treatment'. For example, one has to decide whether life-preserving needs are always more important than life-enhancing needs. Someone whose life is in danger clearly needs treatment more than someone who will survive without treatment, and so it might be argued that life-saving treatment should always be our first priority. But this would disregard other relevant criteria, such as a 'person's age'. According to a research when asked to choose between two patients with identical clinical needs, a huge majority of the public chose the younger patient.[43] Age-based rationing may fuel discrimination against the elderly and increase tension between the older and younger groups of the population and thereby, have a corrosive effect upon society as a whole. As John Harris strongly argues:

---

38 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p. 23. It must be specifically mentioned here that doctors or health authorities are not necessarily well suited to make a moral decision like choosing between two patients' who are equally in need of care.

39 Emily Jackson, *Medical Law, Text, Cases and Materials*, Oxford University Press, 2nd ed. (2010), p.41.

40 Ian Kennedy, *Treat Me Right: Essays in Medical Law and Ethics*, Clarendon Press, Oxford (1988), p.291.

41 Emily Jackson, *Medical Law, Text, Cases and Materials*, Oxford University Press, 2nd ed. (2010), p.42.

42 Id.

43 P Lewis, M Charney, "Which of Two Individuals Do You Treat When Only their Ages are Different and You Can't Treat them Both?", 15 *J Med Eth* 28 (1989).

> A society that accords lower priority in the allocation of resources for healthcare to the old or those with reduced life expectancy is saying, in effect, that their lives are less worth saving, in short, are less valuable. If the right or good done in saving or preserving a life is the less, then so is the wrong done in taking it, which would make, for example, the crime of murder inevitably less serious when the victims are old or terminally ill..
>
> The systematic disvaluing of the old or those with life-threatening illness might have a corrosive effect on social morality and community relations more generally. It might, for example, lead to an increasing tolerance of the idea that any and all resources, or even care, devoted to the old or those with life-threatening disease was a waste of time, money, and emotion…
>
> Moreover, once the old, however defined, had been ruled out of account, the middle-aged would become the old. They would after all have greater elapsed time 'in the bank' and shorter life expectancy ahead than the rest of society and the cycle of argument and discrimination would have a tendency to extend indefinitely, a tendency moreover that would be difficult to restrain.

According to Feek[44], fair and reasonable outcomes in this kind of rationing are produced when clinical guidelines are combined with a review process by courts. The preference for the younger patient was given official recognition in New Zealand where guidelines issued under the Health and Disability Services Act, 1993 included an assumption that patients over 75 should not be accepted for end stage renal failure programmes, as well as categorizing the existence of other serious diseases or disabilities likely to affect the patient's survival or quality of life as reasons for exclusion from the programmes. There are two publicized cases under these guidelines.[45] The first case concerned a man, McKeon, in end stage renal failure who also suffered from coronary artery disease and prostatic cancer. Given dialysis, his expectation of life was about two years; nevertheless, the patient failed the guidelines for the treatment of renal failure. The patient's family laid a complaint of age discrimination with the Human Rights Commission of New Zealand. As a result, the hospital authorities ordered a clinical review of the case. A review of the

---

[44] Feek**,** Colin M**.,** "Experience with Rationing Health Care in New Zealand", 318 *British Medical Journal* 1346 (1999), p.1347.

[45] Kant Patel, Mark E. Rushefsky, *Health Care Policy in an Age of New Technologies*, M.E.Sharpe, Inc., USA (2002), p.222

case by the hospital led to the patient being put on dialysis, though he died a year and a half later. According to one view, the treatment to the patient, served no useful purpose and, have deprived a more deserving claimant of therapy. In the alternative, one can hold that all persons who have lost their kidney function will die at the same rate; all are, therefore, equally entitled to life-saving intervention and their length of survival is immaterial.[46] In *Shortland* v *Northland Health Ltd*[47], W, a 63 year old man suffered from renal failure, diabetes and dementia. A decision was taken to discontinue dialysis, first, on the grounds that W's moderate dementia left him outside the group of persons considered suitable for inclusion in the treatment programme but, later, on a pure clinical and 'best interests' standard. The New Zealand Court of Appeal refused to accept the case as a test of the guidelines, and hence, as a question of rationing, and determinedly held it to be a matter of the exercise of clinical judgment within good medical practice. Accordingly, the court held that the decision to refuse treatment was based on clinical evidence and it is inappropriate for the court to direct a doctor as to what treatment should be given to patient. Thus, this case shows the difficulties inherent in making subjective clinical decisions once general guidelines have been laid down for the use of resources in specific conditions. According to Feek *et al*[48], 'explicit rationing will work only when clinicians accept the link between clinical decision making and resource allocation'. In support of his argument he has quoted the following press comment:

> The reality is that W's case was not a priority. First concerns have to be for patients who are not terminally ill, who do not have other complications and who have a better chance of rehabilitation.

Hence, the most widely acceptable criterion of selection of patients for treatment would be that determined by medical benefit. This is however, easier in theory than to put into practice. As Mason *et al*[49] notes, 'medical benefit is a relative matter and, moreover, prognosis is unpredictable. It is also difficult to avoid the conclusion that the individual's social status may influence the outcome of any therapy-despite the

---

46 J Harris, "What is the Good of Health Care?", 10 *Bioethics* 269 (1996).

47 [1998] 1 NZLR 433.

48 Feek**,** Colin M**.,** "Experience with Rationing Health Care in New Zealand", 318 *British Medical Journal* 1346 (1999), p.1347.

49 JK Mason, RA McCall, GT Laurie, *Law and Medical Ethics*, 6th edn., LexisNexis, UK (2002), p.381.

ultimate medical basis for any decision, access to scarce resources is, then, governed by what are, essentially, non-medical considerations'.

The introduction of the concept of quality adjusted life years or QALYs in UK serves as a helpful framework for difficult allocation of resource issues. The idea behind this is to estimate the number of years of good quality that a given treatment will provide for a patient. To assess QALY's of a person a numerical value is placed on the quality of an individual's life and this is then multiplied by his expected lifespan. The cost of the treatment is then taken into account so that different treatment for different patients can be compared on a purely numerical basis. A year of healthy life expectancy is scored as 1 and a year of unhealthy life as less than 1, depending upon the degree of reduction in quality; while death is valued as 0, a life considered to be worse than death is accorded a minus score. The importance of QALYs is that they do not only measure the amount of extra life that a particular treatment might generate, but also its quality; the assumption being that resources to provide treatment must be diverted where people are offered longest periods of healthy and active life.[50] And this is a far less acceptable application as it clearly operates against the interests of the aged who, put simply, have fewer years to gain.[51] Moreover, assessing the relative quality of two different persons' lives is a subjective exercise which the individual doctor is scarcely qualified to undertake. An important criticism is that the QALY sets no value on life per se.[52] As Harris[53] strongly argues: 'we should be saving as many lives, not life years, as possible'.

Allocation of scarce resources by way of 'patient choice' has been introduced in the State of Oregon where, as a result of extensive public debate, the authorities evolved a list of treatments which will, and will not, be available to those dependent on Medicaid.[54] This way of allocating resources sounds admirable in theory but it has its share of difficulties. As McLean & Mason et al[55] notes: 'any system which depends upon the popular vote tends to marginalize the minorities in

---

50 Emily Jackson, *Medical Law, Text, Cases and Materials*, Oxford University Press, 2nd ed. (2010), p.43.

51 McLean SAM, Mason JK, *Legal and Ethical Aspects of Healthcare*, Greenwich Medical Media Limited, London (2003), p. 25.

52 J Harris, "QALYfying the Value of Life", 13 *J Med Ethics* 117 (1987).

53 Id.

54 McLean, SAM, Mason JK, *Legal and Ethical Aspects of Healthcare*, Greenwich Medical Media Limited, London (2003), p. 19.

55 Id.

the population; thus, say, treatments for conditions peculiar to an ethnic minority may never become readily available'. Hence, one should think very carefully before setting off on the Oregon model.

For these and other reasons, many medical ethicists will maintain that the only just and honest way of relieving the contest for an irreplaceable resource is on the basis of 'first come, first served'. It is, however, a bad medical option because it takes no account of the gravity of the patient's condition and no account of 'medical benefit'-it concentrates on justice and ignores 'welfare'. Although this minimizes the clinical expertise involved, it has the philosophical merits of clarity and impartiality. It also has the pragmatic advantages that the reasoning behind the choice cannot be challenged and that the great majority of patients and their proxies would appreciate its fairness and integrity.[56]

4.4. JUDICIAL RESPONSES TO ALLOCATION OF SCARCE RESOURCES

The first judicial recognition of the issue of limited resources came in *R* v *Secretary of State for Health, West Midlands Regional Health Authority and Birmingham Area Health Authority, ex p Hincks*[57] when the Court of Appeal approved the view that the statutory duty, which could have provided a means to enforcing individual rights to healthcare, is subject to the implied limitation of finite resources. It might, of course, remain open to a patient denied medical care to make an application for judicial review of that refusal. Unless there is some illegality or procedural impropriety in the decision, however, the patient will face an uphill struggle because irrationality will be very hard to prove.[58] For example, in *R* v *Secretary of State for Social Services, ex p Walker*[59], the Court of Appeal refused leave to apply for judicial review of decisions to postpone a non-urgent operation on a premature baby. Sir John Donaldson held that the court could only intervene in the issue of allocation of resources where there is a failure to allocate resources and

---

56 Id. p. 25.

57 [1980] 1 BMLR 93. The case concerned of patients in an orthopaedic hospital who complained that they had waited an unreasonable time for treatment because of shortage of facilities, accordingly they sought a declaration that the Secretary of State and the Health Authorities were in breach of their duty. The patients failed in their action against the Secretary of State.

58 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.27.

59 [1987] 3 BMLR 32. The Court of Appeal refused leave to apply for judicial review of decisions to postpone a non-urgent operation on a premature baby.

referred directly to the public law concept of *Wednesbury unreasonableness*[60]. This is an extremely strict burden to discharge. When a decision about allocating limited funding has been taken with clinical advice, it will be difficult to challenge, not least because the courts will be aware that, by forcing a doctor to treat one patient, it may be requiring the denial of treatment to other patients considered in more urgent need by the medical experts.[61]

The South African Constitutional Court in *Soobramoney* v *Minister of Health KwaZulu Natal*[62], while examining right to health claims set out its approach within the context of limited resources. The court, in considering a terminally ill patient's claim to access medical services to obtain costly dialysis treatment, which had been refused by the local health authority on the grounds of lack of resources, held that the health authority had acted reasonably and applied its guidelines rationally and fairly. In doing so the court asked the crucial question. Has the State done all it could reasonably do in the circumstances? By adopting this approach, the court has recognized that it is not in a position to assume the role of the state in making decisions about resource allocation, but is, instead, there to act as an impartial arbiter.

Supreme Court of India in *Paschim Bang Khet Samity* v *State of West Bengal*[63] while recognizing the obligation of State in providing adequate medical facilities also ruled that state resources are not unlimited:

> No State or country can have unlimited resources to spend on any of its projects. That is why it only approves its projects to the extent it is feasible. The same holds good for providing medical facilities to its citizens including its employees. Provision for facilities cannot be unlimited. It has to be to the extent finances permit. If no scale or rate is fixed then in case private clinics or hospitals increase their rate to exorbitant scales, the State would be bound to reimburse the same.

---

60 *Associated Provincial Picture Houses Ltd* v *Wednesbury Corporation* (1948) 1 KB 223. A reasoning or decision is Wednesbury unreasonable (or irrational) if it is so unreasonable that no reasonable person acting reasonably could have made it.

61 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.27-8.

62 *Soobramoney* v *Minister of Health KwaZulu Natal* 1997 (12) BCLR 1696.

63 *Paschim Banag Khet Samity* v *State of West Bengal* (1996) AIR SC 2426 at p.2429.

Similarly, in *State of Punjab* v *Ram Lubhaya Bagga*[64], the Supreme Court observed that provision of medical facilities to citizens could not be unlimited. It has to be based on availability of financial resources. Though an employee may be given a choice to get treated in any private hospital in the country, the amount of reimbursement may be limited and a committee of experts would decide the limit. The principle of fixing a rate and scale is justified, and cannot be held to violate Articles 21 or 47 of the Constitution.

The Hippocratic Oath explicitly states that: 'into whatsoever house I shall enter, it shall be for the good of the sick to the utmost of my power, holding myself far aloof from wrong... I will exercise my art solely for the cure of my patients...'. This time-honored focus on patient beneficence is threatened when physicians assume responsibility for controlling health care expenditures, or when resource constraints limit their ability to provide reasonable access to necessary services. The allocation of scarce health care resources raises potential legal concerns for physicians. For example, in *Law Estate* v *Simice et al*[65] a British Columbia Supreme Court had to consider the impact of cost containment pressure on a physician's clinical decision. In the case, a patient presented in the emergency room with a headache and later died of an aneurism. One of the issues in the case was why a CT scan was not provided. The defendants argued that resource constraints imposed by the hospital resulted in pressures to use fewer resources, including diagnostic tools like a CT. However, the court was not swayed by the resource constraint argument and held that:

> If it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the Medicare system overall, the former must take precedence in a case such as this. The severity of the harm that may occur to the patient who is permitted to go undiagnosed is far greater than the financial harm that will occur to the Medicare system if one more CT procedure only shows the patient is not suffering from a serious medical condition.

The above statement by the court makes it clear that budgetary constraints must not inhibit physicians from doing what is in the patient's best interest. In another

---

64 1996 (2) SCC 336.

65 *Law Estate* v *Simice* (1994) 21 C.C.L.T. (2d) 228 (B.C.S.C.).

Canadian case, *McLean* v *Carr Estate et al*[66], a patient was admitted to hospital with a head injury and subsequently died. The neurosurgeon on call, determined that a CT scan was unnecessary upon admission. The physician argued that it was not cost effective to do a CT scan on all head-injured patients. The Court stated:

> I do not need to find that every bump on the head would have required a CT scan… it was allegedly too costly in 1987 to do a CT scan on all head-injured patients. I was not, however, provided any evidence to establish that the cost would be prohibitive to scan, not all, but just patients whose skulls had had considerable force applied and who had a resulting skull fracture.

In this case, the physician had determined that it was medically unwarranted to order a CT scan in this particular situation. And while the physician raised the issue of costs, the case turns on the appropriate medical standard of care that should have been provided; that is, because of the severity of the force to the head the court believed that a CT scan was required. It is possible however, to read *McLean* v *Carr Estate*[67] and conclude that the case opens the door for courts to look closely at costs. As Louise and Diane[68] notes though 'the judge might have been recognizing that diagnostic procedures are costly, the determining issue remained that patients must be given treatment as appropriate to their medical status'. In this case, the physician failed to recognize the seriousness of McLean's injury. The above two decisions poses challenges to the physician and raises questions like to what extent should physicians consider, in the course of medical decision-making, decisions to limit services that are intended to accommodate budgetary restraints imposed on or by their health care institutions? Can physicians successfully defend against a claim of negligence by relying on evidence that limitations based on scarce resources, which affect decisions about diagnosis or treatment, are justified?

Interestingly, courts are reluctant to be persuaded by economic arguments when it is to determine whether the actions of an individual physician breached the standard of care and caused harm to the patient. This may be because the courts

---

66 *McLean* v *Carr Estate* (1994) 116 Nfld. & P.E.I.R. 271 (Newfoundland SC).

67 Id.

68 Louise R. Sweatman, Diane Woollard, "Resource allocation decisions in Canada's health care system: can these decisions be challenged in a court of law", 62 *Health Policy* 275 (2002), p. 279.

continue to see the physicians' role as acting in the patient's good and less on the needs of the population as a whole. As Louise and Diane strongly argues that 'to allow economic arguments to factor into the determination of the standard could absolve the physician of blame to the detriment of the patient victim'. However, to not consider the economic arguments is unfair to the physician who is caught between his or her duty to the patient and the reality of the economic restraints that may affect his or her ability to provide the care required.

Despite the judicial reluctance to become involved in questions of allocation of scarce resources, there have been indications that individuals are entitled to basic life sustaining treatment. For example, in *Paschim Banga Khet Mazdoor Samity* v *State of W.B*[69], Supreme Court of India held that 'there is no doubt that financial resources are needed for providing healthcare facilities. But at the same time it cannot be ignored that it is the constitutional obligation of the State to provide adequate medical services to the people'.[70] In *R* v *North West Lancashire Health Authority, ex p A*[71], the court has shown willingness to review treatment decisions for their procedural propriety. The case concerned three transsexuals, A, D and G, who were refused gender reassignment surgery by the health authority. The Authority had a policy in place which allocated a low priority for public funding to procedures considered to be clinically ineffective. The Court of Appeal accepted the legitimacy of such a policy given the need to allocate limited funding. Further, the Court of Appeal emphasized that such a policy must 'genuinely recognize the possibility of there being an overriding clinical need and require each request for treatment to be considered on its individual merits'.[72] This decision requires health authorities to avoid blanket policies refusing to fund treatment and to consider each case on its individual merits. According to Newdick[73], this is 'an important public law principle and its application to decisions of allocation of healthcare resources is a vital development in the protection of patients' healthcare rights'. As a result patient can legally challenge a government policy denying treatment if it does not meet the strict standard of public law.

---

69 (1996) 4 SCC 37.
70 Id. p.48.
71 [2000] 1 WLR 977.
72 Id. p.991.
73 C Newdick, *Who Should We Treat? Rights, Rationing and Resources in the NHS*, 2nd edn, Oxford University Press, Oxford (2005), p.94.

Everyone's right to life must be protected by law, regardless of life expectancy, regardless of quality of life, and regardless of the conflicting needs of healthier, younger and more viable individuals. And while all effective schemes of human rights protection ensure a balance between individual rights and societal interests, it must never be regarded as detracting from the need to protect each individual's fundamental right to life.[74] In a world where healthcare resources are limited, whether inevitably or through a policy choice- an absolute right to receive is simply unrealistic. In *Parmanand Katara* v *Union of India*[75], the Supreme Court of India was emphatic in declaring that the fundamental right to life covered within its scope the right to emergency healthcare. Interestingly, the Supreme Court went on to say that not only Government hospitals, but also 'every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life'. In *Paschim Banga Khet Mazdoor Samity* v *State of West Bengal*[76], the Supreme Court further developed the right to emergency treatment, and went on to state that the failure on the part of the Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21. Similarly, National Consumer Disputes Redressal Commission in *Pravat Kumar Mukherjee* v *Ruby General Hospital & Others*[77], it was held that a hospital is duty bound to accept accident victims and patients who are in critical condition and that it cannot refuse treatment on the ground that the victim is not in a position to pay the fee or meet the expenses or on the ground that there is no close relative of the victim available who can give consent for medical treatment. Despite the very unambiguous reiteration of the right to emergency health care by the Courts, the legal framework has not been developed sufficiently to give effect to this right in

---

74 It is interesting to note a subtle shift in the meaning of the word 'rationing' over the course of the twentieth century. Rationing used to mean that people should be entitled to a fixed quota of resources: an obvious example would be the rationing of food and other goods during and immediately after the Second World War. This was conspicuously egalitarian: deprivation was to be shared equally across society as part of a collective commitment to the national good. Now, however, rationing refers to the discretionary allocation of scarce resources, with deprivation generally distributed unevenly across society.

75 AIR 1989 SC 2039.

76 1996(4) SCC 37.

77 II (2005) CPJ 35 NC.

India.[78] Under Common law, the Court of Appeal while considering the question of a right to treatment in *R (on the application of Burke)* v *General Medical Council*[79] was adamant that there is no such right.

From the Hippocratic perspective, the focus of medical action gravitates around the physician-patient.[80] The physician is obligated to determine what is in the best interests of the patient, and has a fiduciary duty to acquire the resources that are necessary to meet those interests and to advance the good of the patient. The physician must do so regardless of the impact that such actions might have on other persons who might also have a need, on overall healthcare budgets, or on the ability of society to provide healthcare for its members.[81] Hence, if the nature and purpose of medicine are captured by the Hippocratic model, then the fiduciary nature of that model entails that the physician cannot treat allocation issues as genuine issues that involve competition, and cannot approach the scarcity of resources from the perspective of balancing competing rights.[82]

There is a need for development of a broader human rights culture, and ensuring that equality of opportunity and procedural fairness remain central to the implementation of healthcare decisions. Providing basic life-sustaining treatment for

---

78 Admittedly, there are few provisions in some legislation which incidentally cast an obligation to provide emergency medical treatment. For instance, the Motor Vehicles Act, 1988 (Section 134) imposes a duty on the driver of the vehicle and of the doctor and hospital who are approached in case of a motor vehicle accident. Obviously, such piecemeal measures are not adequate by a long shot.
In 2006, the Law Commission looked into the issue, and from a comparative study of the legislations in other countries, suggested a legal right to emergency medical care, reiterating that concerns like legal formalities, monetary considerations or even the infrastructure restraints of the institutions should not stand in the way of providing basic and emergency medical treatment.
It may be noted that hospitals fall within the State list, and therefore, a central act cannot be legislated. The Law Commission therefore, drafted a model bill which can be adopted by the States. As per the recommended model bill, hospitals and medical practitioners would need to initially screen patients to determine if they require emergency medical treatment, and if they do, refusing such treatment without justifiable reason would amount to an offence. A patient may be eventually transferred to another hospital which is better equipped to handle the patient, but the primary responsibility of stabilizing a patient in need of emergency medical care cannot be avoided. This recommendation by the Law Commission is not mere wishful thinking. In fact, it is modeled closely along the lines of the Emergency Medical Treatment and Labor Act, 1986 of the USA.

79 [2005] QB 424.

80 The duties of the physician are embodied in the spirit of the Hippocratic Oath. In the oath, the physician promises, 'Whatever house I may visit, I will come for the benefit of the sick'.

81 Eike-Henner W. Kluge, "Resource Allocation in Healthcare: Implications of Models of Medicine as a Profession", 9 *MedGenMed* 57 (2007).

82 Id.

a patient who needs and desires it is a basic obligation upon a state and an important aspect of patient's right to life and autonomy.[83]

If a patient overcomes the hurdles presented by the shortage of resources and obtains medical treatment, the law's focus will turn to the quality of that treatment. A certain minimum standard of care is imposed upon medical professionals and legal liability might ensue if treatment falling below that standard causes some harm to the patient.

4.5. RIGHT TO QUALITY CARE

The doctor-patient relationship is unique because of the inherent imbalance of power. A patient is by definition in a vulnerable position because a doctor exercises his professional skills upon an ill or injured individual whose very life may lie in the doctor's hands.[84] However, the English courts have not accepted such a classification of the doctor-patient relationship and instead have focused upon implying a duty of care into such a relationship by virtue of its character. The emphasis on doctors' duties rather than patients' rights is infamous and carries with it intrinsic dangers. As Elizabeth Wicks[85] notes:

> If a doctor performs his professional duties competently but the patient suffers some injury as a result of the medical treatment, there is no scope for a vindication of the patient's rights. Similarly, even if a doctor fails in his professional duty and provides treatment in a negligent fashion, unless the patient can prove that this negligence caused physical harm to the patient, the law of torts will fail to compensate the patient for the negligent treatment of the doctor. Of course, these consequences are justified, indeed essential, if the doctor-patient relationship is to continue to be regulated on the basis of a doctor's duty of care, because in neither situation has the doctor's breach of his duty of care caused an injury to the patient and to hold the doctor liable to compensate the patient in such circumstances would be unjust.

However, increasingly, the courts, as well as academic commentators and politicians, are recognizing that the primary goal of healthcare law must be to

---

83 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p. 35.
84 Id.
85 Id.

vindicate the healthcare rights of the patients.[86] This will inevitably necessitate an evolution of the traditional judicial emphasis on a professional standard of care. The regulation of the provision of healthcare and its requisite quality has been primarily regarded as an aspect of law of torts, specifically negligence.

4.5.1. Negligence

The patient has a right to be treated with a reasonable degree of care, skill and knowledge. A mistake committed by a medical practitioner, due to carelessness and lack of competency, will be termed as negligence. In order for a patient to succeed in a claim for negligence against a doctor a patient must satisfy three requirements. Firstly, a patient must establish that a duty of care was owed by the doctor or hospital to him or her; secondly, he must prove that the doctor breached that duty of care by failing to reach the standard of care required by the law; and finally, the patient must prove that his injury or harm was caused by the doctor's negligent act. Each of these requirements is discussed in detail below, with specific emphasis upon the way in which the strict requirements have evolved to incorporate considerations for the rights of the patient.

4.5.1.1. *Duty of Care*

In the healthcare context it is a general assumption that a doctor owes a duty of care to his patient. This assumption is based on the fundamental nature of the doctor-patient relationship which incorporates an obligation of caring as an inherent feature of it.[87] Although it is established that a doctor owes a duty of care to his patient, it is less clear when an individual becomes the doctor's patient.[88] The common law position is that a duty of care is imposed upon the doctor once a doctor has assumed responsibility for the patient's care.[89] As Lord Hewart CJ in *R* v *Bateman*[90] stated:

> 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

---

86 See, *Chester* v *Afshar* [2004] 4 All ER 587, at para 87. Lord Hope stated that the function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached.

87 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.39.

88 See, Chapter 2 for detailed discussion on doctor-patient relationship.

89 Emily Jackson, *Medical Law, Text, Cases and Materials*, Oxford University Press, 2nd edn, 2010, p.104.

90 *R* v *Bateman* (1925) 19 Cr App R 8 (CA), pp.12-13.

> 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.

Hence, it is only when the patient requests the doctor's assistance that the duty of care comes into being. In *Barnett* v *Chelsea and Kensington Hospital Management Committee*[91] a doctor failed to examine three night watchmen who visited the hospital's casualty with symptoms of sickness and nausea after drinking tea. One of the men died with the effects of arsenical poisoning. An issue before the court was whether the doctor had owed the deceased man a duty of care. The court held that the key to answering this question was whether there had been an undertaking of responsibility by the hospital. Nield J held that the doctor owed a duty of care to the patient as an undertaking of responsibility was given presumably by the telephone consultation. Thus, in hospitals, the duty may arise as soon as the patient presents himself for treatment, before he is actually seen by a doctor. Further, in *Wilsher* v *Essex AHA*[92], the Court of Appeal held that a hospital owes patients a primary, non-delegable duty of care to provide properly skilled medical staff and an adequately equipped hospital. In *Parmanand Katara* v *Union of India*[93], Supreme Court of India stated 'every doctor, at the governmental hospital or elsewhere, has a professional obligation to extend his services with due expertise for protecting life'.

Establishment of doctor-patient relationship is of no legal significance unless the patient is able to prove that the physician breached his duty to take care. Hence, the next paragraph discusses issues involved in breach of a duty of care.

4.5.1.2. *Breach of duty of care*

In order for a doctor to breach his duty of care he must fall below the standard of care imposed by the law. In other words, he must have failed to exercise proper skill and care in carrying out the treatment. This raises the question of what is meant by 'proper skill and care'? In general terms, an individual must perform activities involving a risk of harm to others with the care expected of a 'reasonable

---

91 *Barnett* v *Chelsea and Kensington Hospital Management Committee* [1968] 1 All ER 1068.
92 [1987] QB 730.
93 AIR 1989 SC 2039.

person'.[94] Though, the notion of a 'reasonable' person at first sight suggests the care of an 'average' or 'ordinary' individual. However, in practice it suggests that what is required of a person will vary according to the nature of the activity in question. As Lord MacMillan in *Glasgow Corporation* v *Muir*[95] noted: 'those who engage in operations inherently dangerous must take precautions that are not required of persons engaged in the ordinary routine of daily life'. This point is reflected in McNair J's statement in *Bolam* v *Friern Hospital Management Committee*[96] :

> In an ordinary case it is generally said you judge negligence 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. He is the ordinary man. But 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 professing to have that special skill.

Further, in medicine the courts will be careful to judge the defendant's conduct by reference to risks knowable at the time. In *Roe* v *Minister of Health*[97] two patients were paralysed following the administration of contaminated anaesthetic. The contamination had occurred through antiseptic solution seeping through invisible fissures in the storage ampoules, a previously unknown risk. The Court of Appeal found that there had been no negligence. Denning LJ[98] went on to say:

> It is easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks… Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way.

However, the doctors are expected to keep reasonably up to date with medical literature and familiarize themselves with new research findings and techniques

---

94 Marc Stauch, *The Law of Medical Negligence in England and Germany A Comparative Analysis*, Hart Publishing, Oregon (2008), p. 30.
95 *Glasgow Corporation* v *Muir* [1943] AC 448, 456.
96 [1957] 2 All ER 118.
97 *Roe* v *Minister of Health* [1954] 2 QB 66 (CA).
98 Id. p.83.

either showing that an existing technique involves dangers not previously known, or that there is a newer method involving lower risks.[99] Thus, the central feature of 'reasonable skill and care' is how well a reasonable person placed in those circumstances would have acted. As McNair J observed in *Bolam* v *Friern Hospital Management Committee*[100]:

> 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 exercises the ordinary skill of an ordinary competent man exercising that particular art.

Accordingly, a doctor who is particularly skilled will not be negligent if he fails to meet his own exceptional standard on a given occasion provided he still performs as well as a reasonable doctor.[101] In *Bolam* v *Friern Hospital Management Committee*[102], McNair J held what has become *Bolam*[103] test: 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. Accordingly, the standard of care required of a doctor in order to avoid negligence is that of his professional colleagues.[104] Similarly, in *Maynard* v *West Midlands Regional Health Authority*[105], Lord Scarman suggested that the courts should defer to the opinions of

---

99 Andrew Grubb, *Principles of Medical Law*, 2nd edn, Oxford University Press, Oxford (2004), para 6.28.

100 [1957] 2 All ER 118, 120.

101 Marc Stauch, *The Law of Medical Negligence in England and Germany A Comparative Analysis*, Hart Publishing, Oregon (2008), p. 32.

102 [1957] 2 All ER 118. The patient in this case was suffering from mental illness and was subjected to electro-convulsive therapy. During treatment, the patient was not given any relaxant drugs and was unrestrained. He was not warned of the very small risk of fracture. The patient's convulsive movement resulted in dislocation of both hip joints and fractures of the pelvis. The patient alleged negligence but there were two bodies of opinion on the correct procedure for ECT: one body of opinion required restrained of the patient in order to avoid such injuries and the other did not. As a body of medical opinion supported the application of ECT without restraint, there was held to be no breach of the doctor's duty of care and thus no negligence.

103 *Bolam* v *Friern Hospital Management Committee* [1957] 2 All ER 118.

104 For example, Article 4 of the European Convention on Human Rights and Biomedicine states that any intervention in the health field 'must be carried out in accordance with relevant professional obligations and standards'.

105 [1985] 1 All ER 635. The case concerned of two consultants who examined a patient with symptoms which could indicate either TB or Hodgkin's disease. Doctors recommended that the patient undergo an exploratory operation in order to rule out Hodgkin's disease but this operation itself ran a risk of causing damage to the patient's vocal cords. The patient underwent the operation and her vocal cords were damaged. The medical profession was divided on whether the doctors had acted negligently. Applying the *Bolam* test, the House of Lords held that there can be no negligence if there is a responsible body of medical opinion which supports the doctors' actions.

expert witness if they are 'truthfully expressed, honestly held', which implies that the court would scrutinize only the credibility of witnesses, rather than the content of their evidence. The Supreme Court in *Dr. Laxman Balkrishna* v *Dr. Trimbak*[106] held that a doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical professionals.

The consequence of such an approach is that it is doctors rather than judges who are perceived to be setting the standard. This is undesirable as law may be forced to tolerate dangerous practices because of widespread support among professional bodies. In *Bolitho* v *City & Hackney Health Authority*[107], the House of Lords made an attempt to re-assert the judiciary's role in determining the standard of care in medical negligence in contrast to the perception that doctors were judged only by their peers. The court in this case was not willing to blindly accept professional opinion without first being convinced that the medical opinion rested on a 'logical' basis. Similarly, in 2001 the Indian Supreme Court in *Vinitha Ashok* v *Lakshmi Hospital*[108] clarified:

> A doctor will be liable for negligence in respect of diagnosis and treatment in spite of a body of professional opinion approving his conduct where it has not been established to the court's satisfaction that such opinion relied on is reasonable or responsible. If it can be demonstrated that the professional opinion is not capable of withstanding the logical analysis, the court would be entitled to hold that the body of opinion is not reasonable or responsible.

Critics opine that 'logic' is a difficult test to introduce into medical negligence because it will still be rare for a court to dismiss expert evidence that a doctor has acted in a manner consistent with professional standards and practice. As

---

106 AIR 1969 SC 128.

107 [1997] 4 All ER 771. The case concerned a young boy suffering from respiratory distress while in hospital. Despite being called, the senior registrar failed to attend and the boy suffered a cardiac arrest, leading to brain damage and subsequently died. Even if On-duty registrar had examined him, would not have intubated him. Intubation was the only procedure which could have prevented respiratory failure, but it was not without risks. The expert witnesses for each side expressed diametrically opposed views about whether a failure to intubate would have been reasonable. The House of Lords held that the registrar had not breached her duty of care.

108 2001 (8) SCC 731. The Appellant's uterus was removed because of excessive bleeding during a surgery for termination of pregnancy that was discovered to be cervical pregnancy. The Appellant alleged that had a sonography been performed the nature of the pregnancy would have been determined and she would not have had her uterus removed. The Supreme Court observed that there was a difference of opinion among medical experts on whether ultra sonography could determine cervical pregnancy. The Appellant showed no symptoms of cervical pregnancy and there was no reason for the Respondent doctor to suspect that and resort to a different course of treatment.

Wicks[109] strongly argues 'if a number of specialists abide by a particular practice it will almost inevitably have the internal consistency necessary to satisfy logic test to the extent that judges can assess the matter and thus may still be an unreasonable practice to have adopted, particularly when regard is given to patients' rights'. However, the judgment in *Bolitho*[110] has huge significance. The decision has set a process whereby judges scrutinize medical evidence, using the same mixture of common sense and logical analysis that they use to scrutinize other expert evidence in negligence claims against professionals such as architects and accountants.[111]

4.5.1.3. *Causation*

Even if a doctor breaches his duty of care by falling below the requisite standard of care, a patient will only be able to recover damages if that breach can be regarded as causing some harm. Hence, it is not enough to show that the doctor breached his duty of care, and that the claimant's health has deteriorated; rather there must be a causal link between these two facts. For example, in *Barnett* v *Chelsea and Kensington Hospital Management Committee*[112], it was established that the doctor had breached his duty of care to the deceased patient by not examining him personally but the action for negligence failed because, even if the patient had been seen by the doctor, the arsenic poisoning was regarded as too far advanced for an antidote to be effective. Unlike the *Barnett* case, it is not always possible to be certain what would have happened to the claimant if they had, in fact, been properly treated. In medical cases there will often be multiple possible causes, which mean that it will be particularly difficult to prove, on the balance of probabilities, which one caused the claimant's injuries.[113] Thus, the courts have recognized that a very strict application of the causation requirement can result in injustice for the patient. The decision in *Bolitho*[114], for example indicated that if some serious harm has occurred, the courts will look at the entire circumstances of the case before coming to a conclusion as to

---

109 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.44.

110 *Bolitho* v *City & Hackney Health Authority* [1997] 4 All ER 771.

111 Brazier M, Miola J, " Bye-Bye Bolam: A Medical Litigation Revolution?" 8 *Med L Rev* 85 (2000), at p.103.

112 [1968] 1 All ER 1068.

113 Wilsher v Essex Area Health Authority [1998] 1 AC 1074. In this case there were five possible causes of Martin Wilsher's near blindness, one of which was the fact that he had negligently been given excess oxygen on two occasions. The House of Lords found that he had failed to prove that it was the excess oxygen that caused his injuries.

114 *Bolitho* v *City & Hackney Health Authority* [1997] 4 All ER 771.

whether the causation requirement has been satisfied. The House of Lords judgement in *Chester* v *Afshar* [115] represents a significant departure from the traditional requirements of a negligence action. The issue for the court was whether, in the unusual circumstances of the case, justice requires the normal approach to causation to be modified?[116] Lord Hope stated that 'the function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content'.[117] The adaptation of the causation requirement in this case has been the subject of considerable debate and some criticism. Green[118], for example, argues that the law of torts 'is concerned not with compensating all those who have suffered loss, but only with compensating those who have suffered loss as a result of the defendant's breach of duty'. But this decision is encouraging from a human rights perspective that causation requirements should no longer act as a bar to recovery where a patient's rights have been infringed during the provision of healthcare.[119]

4.5.2. Indian View

On the issue of standard of care of medical professionals, Indian courts had adopted and still continue to follow the principle laid down in the *Bolam*[120] case which held that a doctor is not negligent if what he has done would be endorsed by a responsible body of medical opinion in the relevant specialty at the material time.[121]

---

115 [2004] 4 All ER 587. Ms. Chester suffered from severe backache and was referred to a neurosurgeon. Dr. Afshar advised her to go in for surgery. Surgery carried an inherent risk of significant nerve damage in about 1-2% of cases, which was not informed to her. Ms. Chester was partially paralyzed after performance of surgery. She sought damages on the basis that had she been properly informed about the risks of the surgery she could have decided against the operation, or might have at least made other consultations before consenting to it.

116 Id.para 85.

117 Id. para 87.

118 Green S, "Coherence of Medical Negligence Cases: A Game of Doctors and Purses", 14 *Med L Rev* 1, at p.4.

119 Wicks, Elizabeth, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.50.

120 *Bolam* v *Friern Hospital Management Committee*[1957] 2 All ER 118.

121 See**,** *Achutrao Haribhau Khodwa* v *State of Maharastra* 1996 (2) SCC 634. The court held: 'The skill of medical practitioners differs from doctor to doctor. The 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 cases where the doctors act carelessly and in a manner which is not expected of a medical practitioner, then in such a case an action in torts would be maintainable."

Further, in *Jacob Mathew* v *State of Punjab*[122] Supreme Court observed that a simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. 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. In *Dr. L.B. Joshi* v *Dr. T.B. Godbole*[123], the Supreme Court held that a person who holds himself ready to give medical advice and treatment implies that he has enough skill and knowledge for the purpose. He owes a duty of care to the patient in deciding whether to undertake the case and what treatment to give. In *Indian Medical Association* v *V P Santha*[124], the Apex Court decided that the skill of a medical practitioner differs from doctor to doctor and it is incumbent upon the Complainant to prove that a doctor was negligent in the line of treatment that resulted in the death of the patient. Therefore, a Judge can find a doctor guilty only when it is proved that he has fallen short of the standard of reasonable medical care. The fact that doctors are governed by the Indian Medical Council Act and are subject to the disciplinary control of the Medical Councils does not offer any comfort to a person who has suffered due to negligence and such a person has a right to seek redress. The service rendered to a patient by a medical practitioner (except where the doctor renders service free of charge to every patient or under a contract of personal service), by way of consultation, diagnosis and treatment, both medical and surgical, was held to fall within the fold of "service" as defined in Section 2(i) (o) of the Consumer Protection Act, 1986.[125] In India *Bolam* principle has wide acceptance and remained unchallenged because majority of citizens requiring medical care and treatment fall below the poverty line and most of them are illiterate or semi-literate.[126] For majority of them doctor's experience or intuition is acceptable and welcome so long as it is free or cheap; and

---

122 (2005) 6 SCC 1.

123 AIR (1969) SC 128.

124 *Indian Medical Association* v *V.P. Shantha* 1995 (6) SCC 651.

125 Id.

126 *Samira Kohli* v *Dr. Prabha Manchanda & Anr.* 2008 (2) SCC 1, para 26. The case concerned with a patient who had given consent for conducting only diagnostic laparoscopy. As only a diagnostic procedure was to be carried out there was no discussion about any proposed treatment. Her signatures were taken on blank printed papers without giving her a chance for going through the contents. The Supreme court held that in the absence of consent by Samira, the performance of hysterectomy and bilateral salpingo-oopherectomy was held to be an unauthorised invasion and interference with the patient's body amounting to a torturous act of assault and battery and therefore a deficiency in service. The court awarded Rs.25,000 as compensation.

whatever the doctor decides as being in their interest, is usually unquestioningly accepted.[127]They are passive, ignorant and uninvolved in treatment procedures.

In conclusion, there is little doubt that the rights of a patient suffering a preventable adverse event while in hospital have been increasingly recognized by the courts. When the traditional rules of negligence have failed to provide a remedy, the courts have been willing to develop rules to enable a vindication of the patient's rights. Though, the judicial recognition of the need for protection of patients' rights is to be welcomed but, in the quality of healthcare context, it is ultimately unproductive because the rights in question have thus far remained unarticulated and vague.[128]

4.6. CONCLUSION

Autonomy would suggest that individuals have a right to determine what is in their own best interest, though the exercise of the interest may be limited if that right limits the rights of others. Beneficence means that clinicians should act completely in the interest of their patients, and distributive justice or equity implies fairness and that all groups have an equal right to clinical services regardless of race, gender, age, income, or any other characteristic. The utilitarian perspective would suggest that resources for medical care should be used to provide the greatest good for the greatest number. However, in medical care, the "rule of rescue" is often invoked to provide services to the neediest or the most identifiable. A corollary is that therapeutic services are often given primacy over preventive services regardless of their cost effectiveness. Different countries balance the rights of individuals and the fairness in society as a whole in very different ways and use very different processes for addressing the legitimacy, transparency, and accountability of those explicit or implicit decisions.

---

127 Id.
128 Id.57.