Chapter 2

CONCEPT OF
MEDICAL NEGLIGENCE
AN OVERVIEW

"Knowing is not enough: We must apply"
"Willing is not enough: We must do".

McGeer
“Discourage litigation; persuade your neighbours to compromise whenever you can. Point out to them how the nominal winner is often a loser in fees, expenses and cost of time.”

Abraham Lincoln

2.1 INTRODUCTION

The idea of negligence in medical profession overshadows its credibility. First key concept in this design is medical negligence and it requires greater analysis as discussed further. The service which medical professionals render to us is the noblest. Aryans embodied the rule that, Vaidyo narayano harihi (which means doctors are equivalent to Lord Vishnu). Professionals like doctors, lawyers, etc. are in the category of persons professing special skills. Any man practicing a profession requires particular level of learning, which impliedly assures a person dealing with him, that he possesses such requisite knowledge, expertise and will profess his skill with reasonable degree of care and caution. It should be taken in to consideration that the professional should command the “corpus of knowledge” of his profession. Since long the medical profession is highly respected, but today a decline in the standard of the medical profession can be attributed to increasing number of litigations against doctors for being negligent narrowing down to “medical negligence”.

Lately, Indian society is experiencing a growing awareness regarding patient’s rights. This trend is clearly discernible from the recent spurt in litigation concerning medical professional or establishment liability, claiming redressal for the suffering caused due to medical negligence, vitiated consent, and breach of confidentiality arising out of the doctor-patient relationship. The patient-centered initiative of rights protection is required to be appreciated in the economic context of the rapid decline of State spending and massive private investment in the sphere of the health care system and the Indian Supreme Court's painstaking efforts to constitutionalize a right to health as a fundamental right. As of now, the adjudicating process with regard to medical professional liability, be it in a consumer forum or a regular civil or criminal


court, considers common law principles relating to negligence, vitiated consent, and breach of confidentiality. However, it is equally essential to note that the protection of patient's right shall not be at the cost of professional integrity and autonomy. There is definitely a need for striking a delicate balance. Otherwise, the consequences would be inexplicable.³

In the context of obtaining processes, there is a deserving need for a two-pronged approach. On one hand, the desirable direction points towards identification of minimum reasonable standards in light of the social, economical, and cultural context that would facilitate the adjudicators to decide issues of professional liability on an objective basis. On the other hand, such identification enables the medical professionals to internalize such standards in their day-to-day discharge of professional duties, which would hopefully prevent to a large extent the scenario of protection of patient's rights in a litigative atmosphere. In the long run, the present adversarial placement of doctor and the patient would undergo a transformation to the advantage of the patient, doctor, and society at large. Professional negligence, more specifically, medical negligence is, as the term suggests, relates to the medical profession and is the result of some irregular conduct on the part of any member of the profession or related service in discharge of professional duties. But first of all it is essential to analyze what the terms remedy, legal right, legal, duty and most importantly negligence mean.⁴

Negligence is the breach of a legal duty to care. Thus legal duty of a person means the duty the law gives to every person to respect the legal rights of the other. Therefore the legal right of a person can be defined as the provision provided by law to protect the interests of its citizen. We must remember then that where there is a legal right, there is a legal remedy for it. This is inferred from the maxim “ubi jus ibi remedium”.⁵

Negligence is a breach of duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the

⁴ Id.
⁵ An Introduction To Corporate Regulation and Standardization, legal.practitioner.com/regulation/standards_9_3_6.htm
contract of human affairs would do which a prudent and reasonable man would not do. According to Charlesworth & Percy in current forensic speech, Negligence has three meanings. There are: (i) a state of mind, in which it is opposed to intention; (ii) careless conduct; and (iii) the breach of duty to take care that is imposed by either common or statute law. All three meanings are applicable in different circumstances but any one of them does not necessarily exclude the other meanings. The essential components of negligence, as recognized, are three: "duty", "breach" and "resulting damage", that is to say,
1. The existence of a duty to take care, which is owed by the defendant to the complainant.
2. The failure to attain that standard of care, prescribed by the law, thereby committing a breach of such duty; and
3. Damage, which is both causally connected with such breach and recognized by the law, has been suffered by the complainant.

Medical negligence can be seen in various fields like when reasonable care is not taken during operations, during the diagnosis, during delivery of the child, with issues dealing with anesthesia etc. Since this field is very vast the researcher will limit to understanding the basic concepts which are essential for the negligence to be committed. He shall also look into the remedies that the law provides to these patients and on whom the burden of proof lies and when this burden of proof shifts to the other party. He would also be discussing the defenses used by doctors to rescue themselves from the liability and also compare all these things with the English law and also look into the similarities that the Indian law and English law share.

**NATURE OF MEDICAL NEGLIGENCE**

In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. Any reasonable man entering

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7 Jacob Mathew v State of Punjab and Anr., Appeal (Crl.) 144-125 of 2004, decided on 5th August 2005, (2005) 6 SCC 1
8 Vasuprabhath, Medical Negligence in India, December 3, 2011, legalservicesindia.com/article/print.php?art_id=944
into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes shall be exercised with reasonable degree of care and caution. On the same analogy, this assures the patients that a doctor possesses the requisite skill in the medical profession which he is practicing and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. Judged by this standard, a professional including medical professional may be held liable for negligence on one of two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess.⁹

**COMPONENTS OF MEDICAL NEGLIGENCE**¹⁰

Winfield stated that a negligent act comprises of three main components. They are,
- Existence of legal duty
- Breach of legal duty
- Damage caused by the breach

In order to understand the correct meaning of medical negligence it is essential that one carefully analyzes these components because only after one analyzes these components will we be able to understand the remedies that the law provides.

1. Existence of legal duty: Whenever a person approaches another trusting him to possess certain skill, or special knowledge on a given problem the second party is under an implied legal duty to exercise due diligence as is expected to act at least in such a manner as is expected in the ordinary course from his contemporaries. So it is not that the legal duty can only be contractual and not otherwise. Failure on the part of such a person to do something which was incumbent so, that which would be just and reasonable tantamount to negligence. Every time a patient visits a doctor for his ailments he does not enter into any written contract but there is a contract by implication and any lack of proper care can make the erring doctor liable for breach of professional duty.

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2. Breach of legal duty: There is a certainly a breach of legal duty if the person exercising the skill does something which an ordinary man would not have done or fails to do that which an ordinary prudent man would have done in a similar situation. The standards are not supposed to be of very high degree or otherwise, but just the relative kind, that is expected from the person in the ordinary course of treatment.

3. Damages caused by the breach: The wrong, the injury occasioned by such negligence is liable to be compensated in terms of money and the courts apply the well settled principles for determination of the exact liquidated amount. One must remember that no hard and fast rule can be laid down for universal application. While awarding compensation, the consumer forum has to take into account all relevant factors and assess compensation on the basis of accepted legal principles on moderation. It is for the consumer forum to decide whether the compensation awarded is reasonable, fair and proper according to the facts and circumstances of the case.

**STANDARD OF CARE REQUIRED IN INDIA**

There was considerable ambiguity on the standard of care required to be exercised by medical practitioners in order to discharge possible criminal liability arising out of their acts or omissions. Section 304-A of the Indian Penal Code, 1860 [IPC] prescribes punishment for death due to rash or negligent conduct of a person. It is under this section that doctors or other medical practitioners have generally been proceeded against under criminal law. Even though there is protection given to accidents caused during performance of lawful acts [Section 80, IPC] and acts not intended to cause death and done for the person’s benefit by his consent and in good faith [Section 88, IPC], the fear of criminal liability has been lingering during the performance of their duty even today.¹¹

**TESTS USED IN INDIA¹²**

In determining the test for medical negligence and prosecution of medical practitioners, the Supreme Court of India has also issued certain guidelines. What goes to the basis of these guidelines is that once a criminal investigation begins

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¹¹Vasuprabhat, Medical Negligence in India, December 14, 2011
legalservicesindia.com/article/.../medical-negligence-in-india-944-1.h.
¹²Id.
against a doctor, the loss of reputation is nearly irreversible. It has also been taken into account that since the nature of work that doctors perform is one involving public service, it is even more necessary that certain guidelines be issued in this regard.

1. Government of India along with the Medical Council of India should formulate certain rules/regulations etc to regulate aspects of negligence in medical practice. While this exercise is pending, the following guidelines must be kept in mind while prosecuting medical practitioners.

2. To make a case against a doctor, a private complainant has to submit evidence of a prima facie case before the authority taking cognizance of the act. Such authority must also include credible opinion given by another competent doctor to support his case.

3. The investigating officer must also, independently, obtain an impartial and unbiased opinion of a doctor who practices in the same field in the same regard.

4. The doctor concerned should not be arrested like in a regular prosecution. He may be arrested if there is a fear that the doctor will not make himself available for investigation.

Extended ambit of medical negligence

The National Commission as well as the Apex Court in a catena of decisions has held that the doctor is not liable for negligence because of someone else of better skill or knowledge would have prescribed a different treatment or operated in a different way. He is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a reasonable body of medical professionals.

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In Supreme Court the landmark decision Indian Medical Association Vs V.P. Shantha and Others III (1995) C.P.J laid down certain guidelines for medical negligence and defines efficiency of consumer protection. It has held certain exception like

- Service rendered to patient in (free of cost or charity) by a medical professional would not fall under the definition of 'service' under consumer protection act 1986.
- Service rendered by a doctor under contract of personal service was not covered in consumer protection act 1986.

**PROOF OF NEGLIGENCE**

The principle of *Res-Ipsa-Loquitor* has not been generally followed by the Consumer Courts in India including the National Commission or even by the Apex Court in deciding the case under this Act. The Hon'ble Supreme Court\(^{14}\) has held the above view that "All medical negligence cases concern various questions of fact, when we say burden of proving negligence lies on the Complainant, it means he has the task of convincing the court that his version of the facts is the correct one". In one case\(^{15}\), National Commission held that expert opinion in medical negligence played an effective role.\(^{16}\)

**1.2 EVOLUTION OF LAWS GOVERNING MEDICAL PRACTICE IN INDIA**

With the awareness in the society and the people in general gathering consciousness about their rights, measures for damages in tort, civil suits and criminal proceedings are on the augment. Not only civil suits are filed, the accessibility of a medium for grievance redressal under the Consumer Protection Act, 1986 (CPA), having jurisdiction to hear complaints against medical professionals for 'deficiency in service', has given rise to a large number of complaints against doctors, being filed by the persons feeling aggrieved. The criminal complaints are being filed against doctors alleging commission of offences punishable under Sec. 304A or Sections 336/337/338 of the Indian Penal Code, 1860 (IPC) alleging rashness or negligence on the part of the doctors resulting in loss of life or injury of varying degree to the patient. This has given rise to a situation of great distrust and

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\(^{14}\) Dr. Laxman Balkrishna vs. Dr. Triambak, AIR 1969 Supreme Court p\(^{14}\)

\(^{15}\) Sethuraman Subramaniam Iyer vs. Triveni Nursing Home and anr., 1998 CTJ7

fear among the medical profession and a legal assurance, ensuring protection from unnecessary and arbitrary complaints, is the need of the hour. The liability of medical professionals must be clearly demarcated so that they can perform their benevolent duties without any fear of legal sword. At the same time, justice must be done to the victims of medical negligence and a punitive sting must be adopted in deserving cases. This is more so when the most sacrosanct right to life or personal liberty is at stake.\textsuperscript{17}

Medical laws in India are going through a process of evolution. As in England, medical negligence litigation is governed by the general principle of the law of torts. However, all these laws are under development at present, and they will change in future as well, according to the changes in similar laws existing in the UK and the USA. The majority of Indian medical professionals are unaware of these facts. The majority of them are not even aware of the term tort, under which medical negligence cases are tried in civil courts.\textsuperscript{18}

Under Indian law, the remedies available to a person seeking redress for medical malpractice are:

1. Suit for damages under the Civil Procedure Code,
2. Complaint for negligence under the Criminal Procedure Code,
3. Redressal under the Consumer Protection Act, and
4. Medical Council of India for disciplinary action.

Multiple grievance redress facilities often cause confusion in the mind of aggrieved patients. At present, however, they choose to file their case at the various consumer courts under CPA because it is the easiest way. Although there are so many grievance redress facilities, their methods of proving negligence of medical professional are quite similar.

The most radical change in the laws governing medical negligence was the introduction of the CPA in 1986. Under this Act the patients have been equated with consumers. Some significant recent judgments of the Supreme Court of India, like \textit{Laxman Thamappa Kotgiiri}
v. G.M. Central Railway and Others\textsuperscript{19} and Kishore Lal v. Chairman, Employees’ State Insurance Corporation,\textsuperscript{20} decided on 8 May 2007, as well as the judgment of the National Commission in Jagdish Kumar Bajpai v. Union of India,\textsuperscript{21} which will be discussed in details in subsequent chapters, have clearly shown that the laws governing the medical practice have not yet been finalized. The landmark judgment of Apex Court of India in Laxman Thamappa Kotgiri v. G.M. Central Railway and Others\textsuperscript{22} has given the railway employees the right of consumers while availing treatment in a railway hospital free of cost. Similarly, the beneficiaries of ESI Corporation\textsuperscript{23} and CGHS\textsuperscript{24} have also received the right to sue the doctors working in ESI hospitals and CGHS approved hospitals and dispensaries even if the treatment is free of cost. This is in stark contrast to earlier judgments wherein free treatment was considered outside the purview of CPA.\textsuperscript{25} With the consumer movement gaining strength it will be unsurprising, if in the future, all patients receive the right to sue their doctors both in the government and the private sector irrespective of the mode of payment.\textsuperscript{26}

The recent judgment of Supreme Court of India in Samira Kohli v. Dr. Prabha Manchanda and Another\textsuperscript{27} will definitely change the whole procedure of taking consent before a planned surgery. In this case, the doctor was held negligent as she failed to obtain proper informed consent and carried out the operation for removal of uterus. The Apex Court laid down guidelines regarding consent and forbade the surgeons from performing additional surgeries even if it was for the benefit of the patient without obtaining consent for it. This landmark case upholds the right of autonomy of the patient and clearly marks the end of the days of medical paternalism.

This judgment also points out the fact that the patients enjoy certain definite rights which a medical practitioner can not violate. Medical practitioners of our country

\textsuperscript{19} (2007) 4 SCC 596
\textsuperscript{20} (2007) 4 SCC 579.
\textsuperscript{22} (2007) 4 SCC 596
\textsuperscript{24} Jagdish Kumar Bajpai v. Union of India, Revision Petition No. 570 of 2002 decided by The National Commission on 20 October 2005, 2007 MLR 175
\textsuperscript{25} Harbhajan Singh v. Dayanand Medical College, 1994(1) CPR 518; Additional Director, CGHS Pune v. Dr. R.C. Butani, 1(1996) CPJ 255 (NCDRC).
\textsuperscript{26} Supra note106
have hardly ever been taught about the rights of a patient in their medical curriculum. It is now time that they must gain adequate knowledge about the rights of patient so that they do not violate them even unknowingly during their routine practice. They must take into cognizance the changes in doctor-patient relationship that have happened in the last few decades.

As far as criminal cases against doctors are concerned, they are mainly filed following the unnatural death of a patient under section 304A of the Indian Penal Code for a rash or negligent act not amounting to culpable homicide and carry a maximum imprisonment of two years, or a fine, or both. The recent Supreme Court of India judgments in Jacob Mathew v. State of Punjab and Another28 and Dr. Suresh Gupta v. Govt of NCT of Delhi29 have to a great extent determined the laws governing criminal negligence suits against doctors. Since it has given guidelines for prosecuting medical professionals against the charges of criminal negligence, the medical professionals have breathed a sigh of relief. The investigating police officer will have to gather independent and competent medical opinion of a medical professional, preferably from government service, before proceeding against the doctor accused of negligence.

Medical negligence litigation is related to errors in medical practice which should never occur if the basic rules of clinical management are followed, clinical information is accurately recorded and analyzed, and there is appropriate communication with patients. When things go wrong, many patients or their relatives simply want an explanation, instead of taking any legal action, and, by providing explanations, hospitals can reduce the number of medical negligence lawsuits. Unfortunately, in-house grievance redress mechanisms are practically nonexistent in the majority of Indian hospitals.

28 Available at www.judis.nic.in, Criminal Appeal No. 144-145 of 2004 decided by the Supreme Court of India on 5 August 2005, (2005) 6 SCC 1
2.3 TORT LAW-CIVIL LAWS

As an authority\textsuperscript{30} describes, Negligence is the breach of a legal duty to care. It means carelessness in a matter in which the law mandates carefulness. A breach of this duty gives a patient the right to initiate action against negligence.

Persons who offer medical advice and treatment implicitly state that they have the skill and knowledge to do so, that they have the skill to decide whether to take a case, to decide the treatment, and to administer that treatment. This is known as an “implied undertaking” on the part of a medical professional. In the case of the \textit{State of Haryana v Smt.Santra}\textsuperscript{31}, the Supreme Court held that every doctor “has a duty to act with a reasonable degree of care and skill”. Doctors in India may be held liable for their services individually or vicariously unless they come within the exceptions specified in the case of \textit{Indian Medical Association v V P Santha}\textsuperscript{32}. Doctors are not liable for their services individually or vicariously if they do not charge fees. Thus free treatment at a non-government hospital, governmental hospital, health centre, dispensary or nursing home would not be considered a “service” as defined in Section 2 (1) (0) of the Consumer Protection Act, 1986.\textsuperscript{33}

However, no human being is perfect and even the most renowned specialist could make a mistake in detecting or diagnosing the true nature of a disease. A doctor can be held liable for negligence only if one can prove that she/ he is guilty of a failure that no doctor with ordinary skills would be guilty of if acting with reasonable care.\textsuperscript{34} An error of judgment constitutes negligence only if a reasonably competent professional with the standard skills that the defendant professes to have, and acting with ordinary care, would not have made the same error.\textsuperscript{35}

In a key decision on this matter in the case of \textit{Dr. Laxman Balkrishna Joshi v Dr.Trimbak Bapu Godbole},\textsuperscript{36} the Supreme Court held that if a doctor has adopted a

\textsuperscript{30}K K S R Murthy, Medical negligence and the law, Indian J Med Ethics.2007 Jul-Sep;4(3),
\textsuperscript{31}(2000) 5 SCC 182:: AIR 2000 SC 3335
\textsuperscript{32}AIR 1996 SC 550
\textsuperscript{33}See Annexure II .
\textsuperscript{34}Observations of Lord President Clyde in Hunter vs. Hanley (1955) SLT 213.See : Nathan HL. MEDICAL NEGLIGENCE. London: Butterworths; 1957.
\textsuperscript{35}Whitehouse vs. Jordan (1981) 1 All ER 267.
\textsuperscript{36}Dr.Laxman Balkrishna Joshi vs Dr.Trimb Bapu Godbole AIR 1969 (SC)128
practice that is considered “proper” by a reasonable body of medical professionals who are skilled in that particular field, he or she will not be held negligent only because something went wrong.

Doctors must exercise an ordinary degree of skill\(^{37}\). However, they cannot give a warranty of the perfection of their skill or a guarantee of cure. If the doctor has adopted the right course of treatment, if she/ he is skilled and has worked with a method and manner best suited to the patient, she/ he cannot be blamed for negligence if the patient is not totally cured.\(^ {38}\) Certain conditions must be satisfied before liability can be considered. The person who is accused must have committed an act of omission or commission; this act must have been in breach of the person’s duty; and this must have caused harm to the injured person. The complainant must prove the allegation against the doctor by citing the best evidence available in medical science and by presenting expert opinion.\(^ {39}\)

In some situations the complainant can invoke the principle of *res ispa loquitur* or “the thing speaks for itself”. In certain circumstances no proof of negligence is required beyond the accident itself. The National Consumer Disputes Redressal Commission applied this principle in *Dr. Janak Kantimathi Nathan vs Murlidhar Eknath Masane*\(^ {40}\).

The principle of *res ipsa loquitur* comes into operation only when there is proof that the occurrence was unexpected, that the accident could not have happened without negligence and lapses on the part of the doctor, and that the circumstances conclusively show that the doctor and not any other person was negligent.

### 2.4 CONSTITUTIONAL LAW\(^ {41}\)

The Fundamental Rights and Article 21 (Right to Life with Dignity) form the basis of Right to Health. Article 21 of the Indian Constitution, a fundamental right reads: “No person shall be deprived of his life or personal liberty except through procedure


\(^{39}\) Supra Note 123

\(^{40}\) Dr. Janak Kantimathi Nathan vs Murlidhar Eknath Masane 2002 (2) CPR 138.

\(^{41}\) See Annexure III
established by law.” Till the 1970s the courts, by and large, had interpreted ‘life’ literally i.e. right to exist- right not to be killed. In late 1970s, the Supreme Court began to give an expanded meaning to the term ‘life’ appearing in Article 21. Over the years it has come to be accepted that life does not only mean animal existence but the life of a dignified human being with all its concomitant attributes. This would include a healthy environment and effective health care facilities. Today, therefore, the Fundamental Right to Life is seen in a broad context.\textsuperscript{42}

**Context of Judicial Intervention and Evolving Understanding of Right to Health**

To begin with, the right to health as a fundamental right grew as an offshoot of environmental litigation initiated by environmental activists regarding the environment issues. Undoubtedly the right to environment was crucial because a polluted environment affects public health. A pollution free environment as a fundamental right presupposes right to health as a fundamental right. Logically, the explicit recognition of the fundamental right to health should have preceded the fundamental right to good environment. However, the development of jurisprudence in this branch has been the reverse. The right to unpolluted environment was recognized as a right in the first instance and from that followed the right to public health, health and health care. Secondly, the right to health care has also been debated by the courts in the context of rights of Government employees to receive health care. A number of observations of the Court concerning the importance of these rights are to be found in cases dealing with denial or restriction of health care facilities for Government employees, and not to the general masses. This is the context of judicial pronouncements on health care.\textsuperscript{43}

**Public Health is State’s Priority:**

In one of the earliest instances of public interest litigations *Municipal Council, Ratlam v Vardhichand & Ors*,\textsuperscript{44} the municipal corporation was prosecuted by some citizens for not clearing up the garbage. The corporation took up the plea that it did not have money. While rejecting the plea, the Supreme Court through Justice Krishna Iyer observed: “The State will realize that Article 47 makes it a paramount principle of

\textsuperscript{42} Mihir Desai & Chand Dipti, Healthcare Case Law in India, 2007, CEHAT, pp.17
\textsuperscript{43} Supra note, 39
\textsuperscript{44} 1980 AIR 1622
governance that steps are taken for the improvement of public health as amongst its primary duties.”

**Right to Health is a Fundamental Right:**

In 1991, in *CESC Ltd. vs. Subhash Chandra Bose*, the Supreme Court relied on international instruments and concluded that right to health is a fundamental right. It went further and observed that health is not merely absence of sickness:

“The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. Facilities of health and medical care generate devotion and dedication to give the workers’ best, physically as well as mentally, in productivity. It enables the worker to enjoy the fruit of his labour, to keep him physically fit and mentally alert for leading a successful economic, social and cultural life. The medical facilities are, therefore, part of social security and like gilt edged security, it would yield immediate return in the increased production or at any rate reduce absenteeism on grounds of sickness, etc. Health is thus a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. In the light of Arts. 22 to 25 of the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights and in the light of socio-economic justice assured in our Constitution, right to health is a fundamental human right to workmen. The maintenance of health is a most imperative constitutional goal whose realization requires interaction by many social and economic factors.”

**People are entitled to adequate health care**

This was held in *Mahendra Pratap Singh v Orissa State*, as follows.

The petitioner, an ex-sarpanch of Pachhikote Gram Panchayat approached the court for issuance of appropriate writ commanding the opposite parties to take effective measures to run Primary Health Centre at Pachhikote within Korei block in the district of Jaipur by providing all amenities and facilities for proper running of the said health centre. The Government of Orissa decided to open certain primary health centres in different areas in 1991-92 subject to fulfilment of certain conditions, on basis of demands of the local people and public at large.

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45 AIR 1992 SC 573,585  
46 Mihir Desai & Chand Dipti, Healthcare Case Law in India, 2007, CEHAT, pp.19  
47 103 (2007) CLT 675
Adequate and Quality medical care is part of Right to Health and Right to Life:
The Allahabad High Court in *S.K. Garg vs. State of U.P.* was dealing with conditions of public hospitals. The Petition had been filed raising concerns about the pitiable nature of services available in public hospitals in Allahabad. Complaints were made concerning inadequacy of blood banks, worn down X-ray equipment, unavailability of essential drugs and unhygienic conditions. The Court appointed a Committee to go into these aspects and report back to the Court.

In *Paschim Banga Khet Mazdoor Samiti vs. State of W.B.* the Supreme Court though primarily dealing with the issue of obligation of the State to provide emergency health care to patients made a general observation of significance: “Providing adequate medical facilities is an essential part of the obligation undertaken by the State in a welfare state. The Government discharges this obligation by running hospitals and health centres. Article 21 imposes an obligation on the State to safeguard right to life of every person.”

In the case of *Peoples’ Union of Civil Liberties vs. Union of India*, public interest litigation was filed against the Government for backing out of a project to build a psychiatric hospital-cum-medical college in Delhi. The plan had been approved but when it was found that over Rs. 40 Crores would be the expenditure, the Delhi Administration expressed its inability to fund such a project and the Central Government refused to take on its responsibility. The Supreme Court held that setting up of a psychiatric hospital in the capital city was necessary. Once land has been earmarked and on principle a decision taken that hospital should be shifted and part of it should be converted into a teaching institution while the other part should be a hospital, funding should not stand in way of locating such a hospital. As it was difficult to fund such a huge amount in a single year, it was to be taken up as a continuous project spread over a period. Hence, the Central Government and the Delhi Administration were directed to recommence and finish the project.

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48 1999 (1) AWC 847, (1998) 2 UPLBEC 1211
49  AIR 1996 SC 2426, 1996 (4) SCC 37
50 Id
51 (2003) 4 SCC 399
52 Supra pp.23
Compensation Claims against the State

Basis of Compensation by the State: Violation of Article 21 by the State will give rise to a claim under public law remedy.9 The State is also vicariously liable for acts of its agents or police or Government hospitals. The earlier notion was that ‘king could do no wrong’ and the State could not be held liable for the wrongdoings of its servants.

Thus, while public servants could be prosecuted or sued for damages for negligence or dereliction of duty it was not possible for the State to be sued likewise. In the last 20 years this aspect has undergone change. This aspect has also been dealt with in the Chapter 6,53 but the changed principle needs to be elaborated here because it flows partly from the fundamental right to health and health care.54

Anuradha Saha Case 55

The Supreme Court judgment in the Anuradha Saha medical negligence case is a landmark in the annals of medical jurisprudence. The apex court not only adjudicated on how to determine criminal negligence on the part of a doctor or a group of doctors in the event of a patient’s death but also imposed greater responsibility on them on the universal treatment protocol. It has also reinforced a patient’s right to know the line of treatment being followed by doctors, including the risks involved in the treatment56.

The compensation to be paid by AMRI and the doctors individually will be decided by the National Consumer Disputes Redressal Commission, where Kunal has claimed Rs 77.7 Crore as damages. The judgment is being viewed by many as the judiciary’s acknowledgement of the deficiency in the medical service given to Anuradha. The apex court has upheld the Calcutta High Court ruling acquitting three doctors, Dr Abani Roy Chowdhury, Dr.Sukumar Mukherjee and Dr.Baidyanath Halder on the ground that they had no “mens rea (intention) of being rash and negligent”57.

53 Id.
54 Supra note, 23
56 Id.
57 Eshwar Anand, Death by negligence, 02/09/2009, indialawyers.wordpress.com/category/medical-negligence
After a prolonged trial, Kolkata’s Chief Metropolitan Magistrate let off Dr Chowdhury, and the High Court the other two doctors in 2004. Kunal Saha then approached the Supreme Court. Anuradha was diagnosed with a serious disease called Toxic Epidermal Necrolysis (TEN). Also called Lyell’s Syndrome, in this disease, the patient gets high fever and occasionally suffers from somnolence and lassitude. Owing to the extensive area of eroded skin, the patient loses huge body fluid with consequent disturbances in the electrolyte and fluid balance. She died in 1998 at the age of 36 following complications from a steroid overdose.58

Anuradha, a child psychologist, and Kunal, a doctor-researcher on HIV/AIDS, were settled in the US. They visited Kolkata in April 1998 on a vacation. After she suddenly developed fever and skin rash, Dr. Mukherjee examined her and advised her rest without prescribing medicine. After a week, when the skin rash appeared more aggressively, Dr. Mukherjee prescribed Depomedrol injection (80 mg) twice daily for three days. Yet, her condition deteriorated.59

She was admitted to the AMRI hospital on May 11 under Dr Mukherjee’s supervision. Dr. Halder found that she was suffering from erythema plus blisters. Dr Chowdhury also examined her. After her condition worsened, she was shifted to Mumbai’s Beach Candy Hospital in a chartered plane. She died on May 28.60 Medical opinion has been sharply divided over the administration of steroids, particularly for those suffering from TEN, discovered as far back as 1956. In fact, there are pro- and anti-steroid lobbies, implying that medical science has a grey area in this respect. The treatment protocol for TEN has undergone change throughout the world.

Though doctors used to administer steroid for TEN patients earlier, researchers have later warned against its use after conducting tests of TEN patients with and without the administration of steroids. They found that those treated with steroids did not respond properly thereto. Though researchers have found that the use of steroids was more detrimental than beneficial to TEN patients, some doctors still use

58 Id.,
59 Supra note 60.
60 Anuradha’s Story, Oct. 30 2011, pbtindia.com/ anuradhas-story
steroids. In Anuradha’s case, experts held that Depomedrol of 80 mg twice daily should not have been prescribed under clinical conditions.

Though some use “quick acting” steroids for a short period, at the very early stage of the disease, they quickly stop the same to check side, effects. Her condition is said to have deteriorated because, in addition to Depomedrol as prescribed by Dr Mukherjee, she was given a new steroid, Prednisolone (40 mg), thrice daily as prescribed by Dr. Chowdhury and Dr. Halder.

The specialists at Beach Candy Hospital were aghast at this patent steroid overdose on Anuradha by Kolkata’s doctors. According to them, a patient could be given not more than 40 mg Prednisolone, once daily, to be reduced to 5 mg within the next five-six days.

More to the point, as the apex court has observed, the Kolkata doctors did not follow the universal treatment protocol for Anuradha. For a TEN patient, supportive therapy is imperative in character, but no such advice was rendered. Despite well laid down procedures in reputed medical journals, they failed to provide primary emergency care, symptomatic therapy, fluid replacement and antibacterial and nutritional support to Anuradha.

Worse, the fact that AMRI did not maintain records of Anuradha’s vital parameters like temperature, pulse rate, blood pressure, etc, was itself an act of “gross negligence”. Still, the apex court rejected Kunal’s petition to book the doctors for criminal negligence under Section 304-A of the Indian Penal Code. Charging a doctor under this section, according to the Bench, is very serious as it will affect his professional status and reputation and the burden of proof will be more onerous.

It held that a doctor could not be held negligent only because the treatment resulted in the patient’s death. He cannot be held liable for “mischance, misadventure or for an error of judgment” in making a choice where two options are available. Even a doctor’s mistake in diagnosis cannot be necessarily construed as a “negligent diagnosis”, according to the Bench.
Even under the law of tort, a doctor can be held liable in respect of an erroneous diagnosis only if his error is “so palpably wrong” as to prove by itself that it was callously arrived at. For imputing criminal liability on a doctor, a very high degree of such negligence is required to be proved, the Bench ruled.

Interestingly, though experts had briefed the Bench and given their evidence about TEN and its treatment protocol, it ruled that the court was not strictly bound by the specialist advice as such evidence was only advisory in nature under Section 45 of the Evidence Act. The court must derive its own conclusion upon considering the expert opinion, it observed.

The judgment is a watershed in medical jurisprudence because it not only put the onus on the doctors for the patients’ treatment but also laid down ground rules on the basis of its judicial pronouncements over the years. The doctors must observe the current practices regarding infrastructure, sterility and hygiene. No prescription should be given to a patient without actual examination.

A doctor should not merely go by the patient’s version about his/her symptoms but also make his/her own analysis, including tests and investigations wherever necessary. Doctors should not experiment unless necessary and even then only after obtaining the patient’s written consent.

The judgment reinforces a patient’s right to know. The Bench has made it clear that doctors must tell patients about the risks involved in any line of treatment they are following. By and large, patients are ignorant about the adverse effects of a medicine. If some reaction is anticipated, the patient must be informed. This was not done in Anuradha’s case.

The Bench’s warning that whether or not a doctor kept a patient informed about the pros and cons of a line of treatment will be considered in every case of medical negligence hereafter is expected to serve public interest immensely and fill up the vacuum in this vital discipline.
2.5 CRIMINAL LAWS

Indian Penal Code, 1860 sections 52, 80, 81, 83, 88, 90, 91, 92 304-A, 337 and 338 contain the law of medical malpractice in India.

A physician can be charged with criminal negligence when a patient dies from the effects of anaesthesia during, an operation or other kind of treatment, if it can be proved that the death was the result if malicious intention, or gross negligence. Before the administration of anaesthesia or performance of an operation, the medical man is expected to follow the accepted precautions.

In such cases, the physician should be able to prove that he used reasonable and ordinary care in the treatment of his patient to the best of his judgment. He is, however, not liable for an error judgment. The law expects a duly qualified physician to use that degree of skill and care which an average man of his qualifications ought to have, and does not expect him to bring the highest possible degree of skill in the treatment of his patients, or to be able to guarantee cures.

It has long been recognized that criminal liability of a physician may result from a high degree of negligent conduct. What the law calls criminal negligence is largely a matter of degree; it is incapable of a precise definition. To prove whether or not it exists is like chasing a mirage. It requires that any of the following to be established in a case of criminal medical negligence.

“Gross Lack of competency or gross inattention, or wanton indifferences to the patient’s safety, which may arise from gross ignorance of the science of medicine and surgery or through gross negligence, either in the application and selection of remedies, lack of proper skill in the use of instruments and failure to give proper attention to the patient.”

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62 See details in Annexure IV
63 Hampton v State; 425 U.S. 484 (1976) State v Lester, 130 Ohio St.3d 303, 2011-Ohio-5204
In *R. v Bateman*\(^{64}\), Dr. Bateman was prosecuted for manslaughter and the charges of negligence made against him were:

- Causing the internal ruptures in performing the operations of ‘version’;
- Removing part of the uterus along with the placenta;
- Delay in sending the patient to the infirmary.

The trial court convicted him. But the Court of Appeal held: “.. in order to establish criminal liability, the facts must be such that, .... the negligence of the accused went beyond a mere matter of compensation between subjects and should such disregard for the life and safety of others as to amount to a crime against the state and conduct punishment.”

When a FIR (First Information Report) is filed against a doctor for the death of a patient who was under his treatment, under this Indian Penal Code Section 304-A the doctor can be arrested. A doctor charged under this section can obtain bail and if proved guilty, the doctor can be punished with a maximum of two years imprisonment or fine or both. But, if the patient is alive, the doctor is charged under the Indian Penal Code Section 337 and 338.

The Indian Courts have been very careful not to hold qualified physicians criminally (instances of quacks for criminal negligence are there) liable for patients’ deaths that are the result of a mere mistake of judgment in the selection and application of remedies and when the death resulted merely from an error of judgment or an inadvertent death.

**CRIMINAL NEGLIGENCE**\(^{65}\)

Section 304A of the Indian Penal Code of 1860 states that whoever causes the death of a person by a rash or negligent act not amounting to culpable homicide shall be punished with imprisonment for a term of two years, or with a fine, or with both.

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\(^{64}\) [1925] 94 UKB 791
\(^{65}\) Criminal Negligence, laws-lois.justice.gc.ca/eng/acts/C-46/page-107.html
In the *Santra* case\(^{66}\), the Supreme Court has pointed out that liability in civil law is based upon the amount of damages incurred; in criminal law, the amount and degree of negligence is a factor in determining liability. However, certain elements must be established to determine criminal liability in any particular case, the motive of the offence, the magnitude of the offence, and the character of the offender.

In *Poonam Verma vs Ashwin Patel*\(^{67}\) the Supreme Court distinguished between negligence, rashness, and recklessness. A negligent person is one who inadvertently commits an act of omission and violates a positive duty. A person who is rash knows the consequences but foolishly thinks that they will not occur as a result of her/ his act. A reckless person knows the consequences but does not care whether or not they result from her/ his act. Any conduct falling short of recklessness and deliberate wrongdoing should not be the subject of criminal liability.

Thus a doctor cannot be held criminally responsible for a patient’s death unless it is shown that she/ he was negligent or incompetent, with such disregard for the life and safety of his patient that it amounted to a crime against the State.\(^{68}\) Sections 80 and 88 of the Indian Penal Code contain defences for doctors accused of criminal liability. Under Section 80 (accident in doing a lawful act) nothing is an offence that is done by accident or misfortune and without any criminal intention or knowledge in the doing of a lawful act in a lawful manner by lawful means and with proper care and caution. According to Section 88, a person cannot be accused of an offence if she/ he performs an act in good faith for the other’s benefit, does not intend to cause harm even if there is a risk, and the patient has explicitly or implicitly given consent.

**BURDEN OF PROOF AND CHANCES OF ERROR**\(^{69}\)

The burden of proof of negligence, carelessness, or insufficiency generally lies with the complainant. The law requires a higher standard of evidence than otherwise, to support an allegation of negligence against a doctor. In cases of medical negligence the patient must establish her/ his claim against the doctor.

\(^{67}\) 1996(4) SCC 332, 1996 (2) CPJ 1 (SC)
\(^{68}\) House of Lords decision in *R vs Adomako* (1994) 3 All ER 79
\(^{69}\) Medical negligence, [www.supremelaws.in/data/pdf/Medical%20Negligence.pdf](http://www.supremelaws.in/data/pdf/Medical%20Negligence.pdf).
In *Calcutta Medical Research Institute v Bimalesh Chatterjee*, it was held that the onus of proving negligence and the resultant deficiency in service was clearly on the complainant. In *Kanhaiya Kumar Singh v Park Medicare & Research Centre*, it was held that negligence has to be established and cannot be presumed.

Even after adopting all medical procedures as prescribed, a qualified doctor may commit an error. The National Consumer Disputes Redressal Commission and the Supreme Court have held, in several decisions, that a doctor is not liable for negligence or medical deficiency if some wrong is caused in her/ his treatment or in her/ his diagnosis if she/ he has acted in accordance with the practice accepted as proper by a reasonable body of medical professionals skilled in that particular art, though the result may be wrong. In various kinds of medical and surgical treatment, the likelihood of an accident leading to death cannot be ruled out. It is implied that a patient willingly takes such a risk as part of the doctor-patient relationship and the attendant mutual trust.

**RECENT SUPREME COURT RULINGS**

Before the case of *Jacob Mathew v State of Punjab*, the Supreme Court of India delivered two different opinions on doctors' liability. In *Mohanan v Prabha G Nair and another*, it ruled that a doctor's negligence could be ascertained only by scanning the material and expert evidence that might be presented during a trial. In *Suresh Gupta's* case in August 2004 the standard of negligence that had to be proved to fix a doctor's or surgeon's criminal liability was set at “gross negligence” or “recklessness.”

In *Suresh Gupta’s* case the Supreme Court distinguished between an error of judgment and culpable negligence. It held that criminal prosecution of doctors

70*Calcutta Medical Research Institute vs Bimalesh Chatterjee I (1999)CPJ 13 (NC)*

71*Kanhaiya Kumar Singh vs Park Medicare & Research Centre III (1999) CPJ 9 (NC)*

72*Id.*

73*Varsha Narasimhan, Supreme Court and Medical Negligence – Necessary Protection or License to Kill, September 11, 2009, jurisonline.in/.../supreme-court-and-medical-negligence—necessary.*

74*(2005) 6 SCC 1*


76*Dr. Suresh Gupta vs Govt.Of N.C.T. Of Delhi & Anr, (2005) 6 SCC 422*
without adequate medical opinion pointing to their guilt would do great disservice to the community. A doctor cannot be tried for culpable or criminal negligence in all cases of medical mishaps or misfortunes.

On September 9, 2004, Justices Arijit Pasayat and C.K. Thakker referred the question of medical negligence to a larger Bench of the Supreme Court. They observed that words such as “gross”, “reckless”, “competence”, and “indifference” did not occur anywhere in the definition of “negligence” under Section 304A of the Indian Penal Code and hence they could not agree with the judgment delivered in the case of Dr Suresh Gupta.

The issue was decided in the Supreme Court in the case of Jacob Mathew v State of Punjab. The court directed the central government to frame guidelines to save doctors from unnecessary harassment and undue pressure in performing their duties. It ruled that until the government framed such guidelines, the following guidelines would prevail:

‘A private complaint of rashness or negligence against a doctor may not be entertained without prima facie evidence in the form of a credible opinion of another competent doctor supporting the charge. In addition, the investigating officer should give an independent opinion, preferably of a government doctor. Finally, a doctor may be arrested only if the investigating officer believes that she/ he would not be available for prosecution unless arrested’.

2.6  CONSUMER PROTECTION ACT, 1986

Consumer Protection Act and the medical profession: One of the most hotly debated areas in the field of consumer law is that of medical negligence and the issues arising from it. The issue of what amounts to medical negligence in India and when can a doctor/medical professional be said to be negligent in the performance of his duties, and the standard of care that a doctor is expected to meet in his practice has been the topic of a number of landmark decisions/cases in India. The fact that the

77 AIR 2005 Supreme Court 3180

medical profession and the services this sector has to offer are covered within the ambit of Consumer Protection Act is well settled.\textsuperscript{79}

The Consumer Protection Act was enacted in 1986 “to provide for better protection of the interests of consumers”. It creates a parallel dispute redressal mechanism and provides for a time limit within which disputes need to be adjudicated upon, making the remedy one of the most favoured with litigants. Under the scheme of the Consumer Protection Act, 1986, any person who hires or avails of any service for consideration (and includes any beneficiary of such services) qualifies to be a consumer, as per the definition in Section 2(d) of the Act. In the event that the services hired or availed of by a consumer suffer from deficiency in any respect, the consumer can approach the consumer fora for redressal of his grievances and for remedies provided under the Act. Deficiency has been defined under the Act as any fault, imperfection or shortcoming in the quality, quantity, potency, purity or standard. Clearly this is a very wide definition, and the determination of this would depend upon and differ in each case.

The consumer protection Act was brought into existence for the protection of interests of the consumer and for settlement of consumer dispute, within a limited time frame and with fewer expenses. In April 1992, the National Commission, on appeal from the Kerala State Commission decided that the medical services be covered under COPRA. This enables a consumer (patient) to make a complaint to a redressal forum in respect of a defective service, if the service has been paid for. Defective in the context of a doctor's services means negligent. Deficiency or negligence means fault or imperfection, shortcoming or inadequacy in quality, nature and manner of performance of the medical service rendered by a hospital and/or member of the medical profession. Several amendments in the Act have been passed in the Consumer Protection (Amendment) Act 1993.

Consumer Disputes Redressal Forums have been established at three different levels as given below. (Section 9)

\textsuperscript{79} P.N. Mehta, Consumer Protection Act and Medical Profession, www.indianpediatrics.net/sep1997/845.pdf
1. ‘District Forum’ by the State Government in each district of the state by notification. The jurisdiction to entertain complaints is limited to those where the value of the goods or services and the compensation, if any claimed, does not exceed rupees 20 Lakh.

2. ‘State Commission’ by the State Government in the state by notification. It compensation, if any, claimed exceeds rupees 20 Lakh but does not rupees 1 Crore and appeals against the orders of any District forum within the state. It can call for the records and pass appropriate order in any consumer dispute which is pending before or has been decided by any District Forum within the state, where it appears to the State Commission that such District Forum has exercised a jurisdiction not vested in it by law, or has failed to exercise a jurisdiction so vested or has acted in exercise of its jurisdiction illegally or with material irregularly.

3. National Commission’ (National Consumer Disputes Redressal Commission) by the Central Government. It has the jurisdiction to entertain complaints, where the value of the goods or services and compensation, if any, claimed exceeds rupees 1 Crore and appeals against the orders of any State Commission. It can call for the records and pass appropriate orders in any consumer dispute, which is pending before or has been decided by any State Commission, where is appears to the National Commission that such State Commission has exercised a jurisdiction not vested in it by law, or failed to exercise a jurisdiction so vested, or has acted in the exercise of its jurisdiction illegally or with material irregularity.

Negligence can be established by a complainant after the production of expert evidence, indicating the negligence, and in the absence of such evidence, the opposite party cannot be said to have been negligent in the treatment of the patient.

**Who is a consumer? (Section (1) (d))**

Any person who buys any goods against consideration is a consumer (it also includes any user of such goods, other than the person who buys such goods, where such use is made with the original buyer’s approval.) However, if the goods are purchased for resale or any commercial purpose, then the buyer is not a consumer and cannot avail the protection under this Act.
Similarly, any person who hires services against consideration is also a consumer and it included any beneficiary of such services, of course with the approval of the original consumer. Strictly speaking, the definition penetrates the essence of consumption and not merely the dereliction based on privity between the parties. Any user of goods or beneficiary of services has also a legal right and locus standi to initiate action under the act. In the course of treatment of a patient, the bills and fees of the doctors may be paid by an attendant or family member. The patient, as beneficiary, remains consumer. The madras high court while deciding Bench of writ petitions in Dr. C.J Subramanian v. kumaraswamy, 80 interpreted the provision of the act vis a vis medical practitioners as under:

i. The services rendered to a patient by a medical practitioner or a hospital by way of diagnosis and treatment both medical and surgical, would not come within the meaning of ‘service’ as defined in section 2 (1)(o)of the Consumer Protection Act

ii. A patient who undergoes treatment under a medical practitioner or a hospital by way of diagnosis and treatment, both medical and surgical, cannot be considered to be a ‘consumer’ within the meaning of section 2(1) (d) of the Consumer Protection Act. 81

iii. The medical practitioner or the hospital undertaking and providing paramedical services of any category or kind cannot claim similar immunity from the provision of the act and they would fall, to the extent of such services rendered by them, within the definition of service and a person availing of such service would be a ‘consumer’ within the meaning of this act. The issue now stands finally decided by the supreme court in V.P Shantha’s case; Indian medical association v. V.P Shantha.

Patients who avail medical services of government hospitals, where no fee or consideration is charged except a nominal amount as registration charges cannot fall within the ambit of “consumer:”

81 Refer to Annexure II.
**What is service? [Section 2 (1) (o)]**

Services are defined in a wide terminology to include most of the general facilities which a consumer avails in day to day activities. A very comprehensive definition of services has been incorporated in the Act. It says ‘service’ means service of any description which is made available to potential users. The word ‘potential’ gives any potential user the right to move under this Act. But rendering of any service free of charge or under a contract of personal service does not come under the ambit of this act. Services rendered by doctors and hospital have been held to be within the jurisdiction of the Act.
RIGHTS OF THE PATIENT  

To understand the depth of the logic applied by the consumer courts it is essential that we understand what rights a patient enjoys as a consumer, for the breach of which he can ask for a legal remedy. The rights of a consumer as a patient in the Act are based on the inherent rights. These inherent rights are-

- The right to be protected against marketing of goods and services which are hazardous to life and property. So one should always sport an attitude of ‘beware! Don’t sell me goods hazardous to my life and property’;
- The right to be informed about the quality, quantity, potency, purity, standard and price of goods or services, or as the case may be, so as to protect the consumers against unfair trade practices;
- The right to be assured, whenever possible, access to a variety of goods and services at competitive prices;
- The right to be heard and to be assured that the consumers interests will receive due considerations at appropriate forums;
- The right to seek redressal against unfair trade practices or restrictive trade practices or unscrupulous exploitation of consumers; and
- The right to consumer education.

Hence a consumer can keep in mind these rights and these important conditions of the consumer protection act before filing a suit in the court regarding medical negligence in India.

Generally there is always confusion whether medical negligence is a tort or is it a deficiency in service. In Dr. Ravinder Gupta v. Ganga Dev case it has been observed that before the consumer protection act was proposed the laws related to medical negligence was always under the law of torts only. Medical liability under the consumer jurisdiction is on a somewhat different footing and though in certain areas the matter (consumer law & tort law) may overlap, there is a clear line distinction between the two, medical liabilities within the consumer jurisdiction is only a species of the genus of deficiency in services hired. The definition casts the very net wide and extends the somewhat narrower concept of negligence in the law of torts.

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\(^{82}\) Supra 43  
\(^{83}\) 1993(3) CPR 255,
Medical liability under the consumer jurisdiction undoubtedly includes what is negligence in the law of torts, but is somewhat wider and more than the strict liability under the law of torts. A practitioner can be held to be liable if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regard being to the ordinary level of skill in the profession.

**LIMITATION PERIOD**

The District Forum, the State Commission or the National Commission shall not admit a complaint unless it is filed within two years from the date on which the cause of action has arisen, unless the complaint satisfies the forum or the commission as the case may be, that he had sufficient cause for not filing the complaint within such period and the reason for condoning such delay is recorded.

Any appeal preferred from the order of the district or the State Commission under the Act, must be filed within thirty days of the order.

Under s 23 of the Act, any person, who is aggrieved by an order made by the National Commission whether in its original or appellate jurisdiction has a right to prefer an appeal to the Supreme Court within a period of 30 days will not stand as a bar, if the Supreme Court is satisfied that there has been a sufficient cause for not filing it in the period.

A final order is required to be passed within 90 days of the issue of the notice or the receipt of the complaint filed by the opposite party if the goods forming subject matter of the dispute are not required to be sent to a laboratory for testing, and 150 days if such testing is required to be done. No time limit has been laid down for the disposal of an appeal or revision petition.

Thus it is clearly seen from the provisions available to a consumer that, within certain stipulated time the judgment must be passed at both the levels, National Commission and Supreme Court. In reality, over last 3 decades, the period for hearing and final judgment ranges between 5 to 6 years, thus the very purpose is defeated by delaying the justice.

84 Id.
PENALTY
In case of dismissal of frivolous or vexatious complaints—where a complaint instituted before the District Forum, the State Commission or, as the case may be, the National Commission, is found to be frivolous or vexatious, it shall for the complainant shall pay as penalty to the opposite party such cost, not exceeding ten thousand rupees, as may be specified in the order.

Thus, District Forums have original jurisdiction, while the State and the National Commission are vested with original, appellate and revisional jurisdictions.

As per the judgment of the Supreme Court of India, in Indian Medical Association v V.P. Shantha &Ors85, the medical services delivered on payment basis, clearly fall, within the ambit of the Act. Similarly, the hospital or the nursing homes, which provide free service to some of the patients who cannot afford to pay the fees, but the bulk of the service is rendered to the patient on payment basis, are also covered under this treatment and all the charges for consultations, diagnosis and medical treatment are borne by the insurance company, the service rendered to him by a medical practitioner would not be free of charge and would, therefore, constitute service as defined in the Act.

The Supreme Court judgment also enlarges the definition of negligence by enunciating that violation of an established law is also negligence and where a service provider is guilty of such negligence, no further proof is required to hold him liable for his action.

COMPENSATION86
At the threshold of a claim for compensation upon negligence to be established, it needs to be proved that:

- the defendant owed a duty of care to the consumer;
- there has been a breach in the performance of that duty; and

85 AIR 1996 550
86 Id.
There should be some consequent loss caused to the person.

Early on, the Supreme Court of India has in *Dr. Laxman BalKrisha Joshi Vs. Trimbak Bapu Golbole & Another* \(^{87}\) held that:

“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 consulted by a patient owes him certain duties, viz, 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 a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires. The doctor, no doubt, has discretion in choosing the treatment which he proposes to give to his patient and such discretion in relatively higher in cases of emergency.”

In UK, the issue of medical negligence was considered in great detail in the case of *Bolam Vs. Friern Hospital Committee* \(^{88}\), when McNair, J. held that “in the case of a medical man negligence means failure to act in accordance with the standards of reasonably competent medical men at that time” and that “there may be one or more perfectly proper standards, and if the medical man conforms with one of those proper standards he is not negligent”. The English view is 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 men. But what amounts to reasonable conduct should only be decided upon by the court, based on the views of the experts in the field. As to what other medical professionals do in similar situations, will be a material consideration to be weighed by the court.

The view in *Bolam*s case was finally accepted in India after 2 decades in the landmark case of *Dr. Suresh Gupta*.\(^5\) However, that case got referred to a larger

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\(^{87}\) AIR 1969 SC 128
\(^{88}\) 1957,1 WLR 583
bench of the Supreme Court and finally in *Jacob Matthew* and *Shiv Ram* the *Bolam* Test was approved. Recently, the Supreme Court has given far reaching guidelines on medical negligence in *Martin F. D’Souza Vs. Mohd Ishfaq*, while following *Jacob Matthew* held as under:

“The law, like medicine, is an inexact science. One cannot predict with certainty an outcome of many cases. It depends on the particular facts and circumstances of the case, and also the personal notions of the Judge concerned who is hearing the case. However, the broad and general legal principles relating to medical negligence need to be understood.

Before dealing with these principles two things have to be kept in mind:

(1) Judges are not experts in medical science, rather they are lay men. This itself often makes it somewhat difficult for them to decide cases relating to medical negligence. Moreover, Judges have usually to rely on testimonies of other doctors which may not necessarily in all cases be objective, since like in all professions and services, doctors too sometimes have a tendency to support their own colleagues who are charged with medical negligence. The testimony may also be difficult to understand, particularly in complicated medical matters, for a layman in medical matters like a Judge; and (2) A balance has to be struck in such cases. While doctors who cause death or agony due to medical negligence should certainly be penalized, it must also be remembered that like all professionals doctors too can make errors of judgment but if they are punished for this no doctor can practice his vocation with equanimity. Indiscriminate proceedings and decisions against doctors are counterproductive and serve society no good. They inhibit the free exercise of judgment by a professional in a particular situation”.

In the above mentioned background The Supreme Court has further directed that:

“…whenever a complaint is received against a doctor or hospital by the Consumer Fora (whether District, State or National) or by the Criminal Court then before issuing notice to the doctor or hospital against whom the complaint was made the Consumer Forum or Criminal Court should first refer the matter to a competent doctor or

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89 AIR 2009 SC 2049
90 Id. pp. 6-7
committee of doctors, specialized in the field relating to which the medical negligence is attributed, and only after that doctor or committee reports that there is a prima facie case of medical negligence should notice be then issued to the concerned doctor/hospital. This is necessary to avoid harassment to doctors who may not be ultimately found to be negligent.”

The rationale behind this decision shows a divergence from the traditional English view, that “The courts and Consumer Fora are not experts in medical science, and must not substitute their own views over that of specialists…”

**Consent for medical treatment**

Consent is material to all medical treatments, with the exception of emergent medical care, when consent can be waived/ deferred. The basis for recognizing consent to medical treatment is the individual’s right to autonomy or self-determination. As stated by Cardozo, J:

“Every human being of adult years and sound 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.”

Consent to treatment could be expressed or implied by the patient’s conduct. Once a patient has come to the doctor for treatment and paid the professional fee, he is said to have impliedly consented to the treatment; such a consent being valid only for examination and not for the performance of any procedure.

The Indian Medical Council (professional conduct, etiquette and ethics) Regulations, 2002, regulation 7.16 requires that:

“7.16: Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of minor, or the


92 Supranote 72.
93 Supra note 78.
patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed.\textsuperscript{94}

For there to be a valid consent, it is necessary to ensure that the consent is always expressed in writing. Often standard consent forms only indicate that the general nature and purpose of the treatment have been explained to the patient. They are not always conclusive of the fact that the patient consented to the procedure in question. In \textit{Chatterton Vs. Gerson} \textsuperscript{95} the court held that “getting the patient to sign a pro forma expressing consent to undergo an operation ‘the effect and nature of which have been explained to me’ as was done here in each case, should be a valuable reminder to everyone of the need for explanation and consent...The consent would be expressed in form only, not in reality.”

For the consent to be valid in law, it must be an informed consent. The patient must consent to the treatment after understanding the nature of the treatment. Before this, he must have some information about the procedure itself. \textsuperscript{96} Without appropriate/adequate consent, a doctor might face the risk of proceedings for assault/causation of injury, in case of any complication arising from the medical procedure. Therefore, to protect him in case of future litigation, it is important for a doctor to have a written consent form, where it should be specified that the procedure, including its risks, has been explained to the patient, and the patient has thereafter decided to go ahead with the treatment. It is advisable to get the form signed in the presence of an independent witness apart from a family member/attendant of the patient. For high risk cases, it is advisable to have a separate form specifying the details of the added risks and the nature of the procedure.

\textbf{In case of children} \textsuperscript{97}

The difficulty arises in relation for consent of a child. Jones\textsuperscript{12} divides children into two categories:

\textsuperscript{94} See in Annexure. IV  
\textsuperscript{95} [1981] QB 432  
\textsuperscript{96} Chatterton Vs. Gerson [1981] QB 432 & Samira Kohli Vs. Dr. Prabha Manchanda; SC (2008) 2 SCC 1  
\textsuperscript{97} Id.
• Those who have the capacity to make their own decisions about medical treatment and can give valid consent on their own
• Those who do not have the capacity, in which case parental consent becomes necessary

As per the Indian Majority Act, 1875⁹⁸, a person attains majority upon the completion of eighteen years of age. A person below the age is a minor.

The English view in *Gillick Vs. West Norfolk and Wisbech Area Health Authority*⁹⁹ is that if the patient is capable of understanding what is proposed, and of expressing his or her own wishes, there is no good reason for holding that he or she lacks the capacity to authorize the doctor to perform an examination or give treatment.

But in cases where the minor (child) lacks the relevant capacity to consent to treatment, parental consent is required unless there is an emergency. As per *Gillick*, parental rights to control a child exist only for the benefit of the child and extend to only so far as they extend them to protect the interests of the child. A slightly different approach was taken by the court in the case of *Re T. (a minor) (wardship: medical treatment)* in which a child was born with a life threatening liver defect. The doctors indicated that the child was likely to have a normal life if it underwent a liver operation, but the mother refused to give her consent. Under wardship jurisdiction, the judge granted permission for the operation in the best interests of the child, but the Court of Appeal held that the welfare of the child depended on the mother, who would be expected to care for him for many years. Thus, the mother’s views were held to be relevant, even though the doctors felt that the same was unreasonable.

From this it would follow that it is imperative to get the consent of the parents in cases such as these. An option would be to get an order from the court allowing the treatment despite lack of parental consent. Such an order would protect the interests of the doctor, in case he decides to go ahead with the treatment, even though the parents have indicated their views against the same.

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⁹⁸The Indian Majority Act, 1875 ¹ http://www.indiankanoon.org/doc/1124939/
⁹⁹[1986] 1 AC 112, [1985] 3 All ER 402,
Emergencies

In India, after Pt. Parmanand Katara’s case\textsuperscript{1990} in the context of emergent care of medico-legal cases, it was clarified that “Every injured citizen brought for medical treatment should instantaneously be given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death. There is no legal impediment for a medical professional when he is called upon or requested to attend to an injured person needing his medical assistance immediately…Preservation of human life is of paramount importance that is so on account of the fact that once life is lost, the status quo ante cannot be restored as resurrection is beyond the capacity of man…Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life…Every doctor should be reminded of his total obligation and be assured of the position that he does not contravene the law of the land by proceeding to treat the injured victim on his appearance before him either by himself or being carried by others.” Doctor can provide medical treatment to a child in the absence of parental consent in an emergency, based on the principle of necessity. But what happens in case parents refuse consent to a treatment that could be life saving for a child? Will the doctor be justified in performing the treatment in the light of express prohibition?

It seems that while this position of law is not entirely clear, it could be argued that in some cases, the doctor can act in disregard of parental prohibition. Here the words of Lord Templeman in the Gillick Case are to be noted:

“I accept that if there is no time to obtain a decision from the court, a doctor may safely carry out treatment in an emergency if the doctor believes the treatment to be vital to the survival or health of an infant and notwithstanding the opposition of a parent or the impossibility of alerting the parent before the treatment is carried out. In such a case the doctor must have the courage of his convictions that the treatment is necessary and urgent in the interests of the patient and the court will, if necessary, 

\textsuperscript{1990} Id.

\textsuperscript{1991} CRI. L. J. 671
approve after the event treatment which the court would have authorized in advance, even if the treatment proves to be unsuccessful\textsuperscript{102}

In so far as a doctor’s liability in Intensive Care in concerned, the basic principles stated above can be applied to such situations. The courts have recognized that the purpose of saving a life can justify taking risks, which have to be balanced against the consequences of not taking the risk. They also have to be weighed in light of the expected benefits to the patient. Thus, if the chances of a patient’s survival are not very high, it would justify taking greater risks and vice versa.\textsuperscript{103}

SAFEGUARDS\textsuperscript{104}

As in all medical negligence cases, even for minors in the Intensive Care Unit (ICU), the most vital safeguard against an action under the Consumer Protection Act, 1986, or civil liability would be to exercise the necessary degree of care, not only in discharging the duties, but also in recording the manner in which the treatment has progressed.

It would be advisable to maintain files/records even for out patients, and all documentation to be recorded therein. The prescriptions/summaries that are prepared during taking of history/diagnosis/treatment be recorded in detail, and the differential diagnosis also be recorded. It is sometimes impossible for a doctor to recollect the incident after a long time has elapsed between the incident and the complaint, and this would only serve as a tool for refreshing of memory. It would also help the patient’s family/attendants in analyzing the course of treatment being given to him, and also enable any other medical professionals that he may consult subsequently to make informed decisions. All advice that is given to the patient or communicated to family members/guardians, such as precautions that need to be taken should also be noted and confirmation (in writing) taken from the family members/patient. At times, it is possible that the patient suffers damage because of not following medical advice; it becomes essential to show that such advice was in fact given to the patient. Detailed consent forms describing the risks of the procedures that are being undertaken should be considered with a view that the well-

\textsuperscript{102} 1986.1 AC 112
\textsuperscript{103} Michael A. Jones, Medical Negligence, Sweet & Maxwell, London, 1991, P.82
\textsuperscript{104} Supra 72.
known and most likely complications and pitfalls of various procedures are informed to the patient and the guardian/parent in advance. While all this may lead to more paperwork and reduce the medical professional’s dealing time, in the longer run, the benefits of the comprehensive case histories/treatment records would deter vexatious/frivolous litigation/claims.

JURISDICTION OF CONSUMER COURTS

Medical negligence gives rise to civil and criminal liability. As already mentioned that as regards civil wrongs, an aggrieved person can claim compensation either through a civil suit or a complaint lodged with consumer forum. Since the enactment of Consumer Protection Act, 1985 there has been a significant rise in medical negligence cases being filed. In one sense, the passing of this law has given a boost to consumers for approaching courts in respect of negligence.

For quite some time after the passage of the Consumer Protection Act, furious debate was raging whether it at all applies to doctors, hospitals and nursing homes and if so under what situations. The Supreme Court finally set at rest this controversy in the case of Indian Medical Association vs. V.P. Shantha. The Court held that proceedings under the Consumer Protection Act are summary proceedings for speedy redressal and the remedies are in addition to private law remedy. The issue was whether patients are consumers under the Consumer Protection Act and could they claim damages for injury caused by the negligence of the doctor, hospital or nursing home.

Apart from submitting that patients could not be classified as consumers under the Consumer Protection Act, the Medical Association argued the following points that are briefly reproduced

a) Deficiency in service, as defined under the Act, means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained under any law or has been undertaken to

106 1996 AIR 550
107 Id.
be performed by a person in pursuance of a contract or otherwise in respect to any service. Thus, deficiency is ascertained on the basis of certain norms relating to quality, nature and manner of performance, and since medical services cannot be judged on the basis of any fixed norms, therefore, practitioners are not covered under the definition of ‘services’.

b) Only such persons can fairly and justly decide on medical malpractice cases who are themselves qualified in medical field as they will be able to appreciate the complex issues involved in such cases. The District Forum comprises of President who is or was a District Judge and the other two members who shall be persons having adequate knowledge or experience of, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration. Similarly State Commission and National Commission comprise of two non-judicial members who are concerned with economics, law, commerce, accountancy, industry, public affairs or administration, while the President shall be a person who is or was a judge of a High Court and Supreme Court, respectively. It was submitted that as the members of the Forum are not qualified to deal with medical malpractice claims medical practitioners should be exempted from the ambit of the Act.

c) Medical malpractice claims involve complex issues that will require detailed examination of evidence, deposition of experts and witnesses. This is contrary to the purpose of summary proceedings involving trial by affidavits, which is to provide speedy results. Hence Consumer Forum should not adjudicate medical malpractice cases.

d) If the medical practitioners are brought within the purview of the Act, the consequences would be a huge increase in medical expenditure on account of insurance charges as well as tremendous increase in defensive medicine, that medical practitioners may refuse to attend to medical emergencies and there will be no safeguards against frivolous and vexatious complaints and consequent blackmail.

The Supreme Court, however, rejected all these arguments and held,
a) The Act defines ‘consumer’ as any person who *hires* or *avails* of any services for a *consideration* which has been paid or promised or partly paid and partly promised
under any system of deferred payment and includes any beneficiary of such services other than the person who hires or avails of the services for the consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person.

‘Service’ means service of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, boarding or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information, but does not include rendering of any service free of charge or under a contract of personal service.

The Supreme Court observed that all services are included other than those that are provided for free or under a contract of service.

b) The next question was on what parameters of deficiency in services of medical practitioners, hospitals or nursing homes should be ascertained. Section 14 enumerates the relief that can be granted for deficiency in service. Sub-section 1(d) provides compensation for any loss or injury suffered by a consumer due to negligence of the opposite party. A determination of deficiency in services has, therefore, to be made by applying the same test as is applied in an action for damages for negligence. The test is the standard of medical care a reasonable man possessing same skills and expertise would employ under same circumstances. A medical practitioner need note Exhibit extraordinary skills.

c) As regards the expertise of the member of the consumer forum to adjudicate on medical malpractice cases the Supreme Court observed that the object of the Act is to have members who have required knowledge and experience in dealing with problems relating to various fields connected with the object and purpose of the Act, which is to protect the interest of the consumers. Also as person who is well versed in law and has considerable judicial or legal experience heads all the forum, it will ensure that the deliberation on cases will be guided by legal principles. To say that
the members must have adequate knowledge or experience in the field to which the complaints are related would lead to impossible situation. If the jurisdiction is limited to the area of expertise of its members then complaints relating to large number of areas will be outside the scope of the Act as the two members in the District Forum have experience in two fields. The problem will arise vertically as at particular times in State Commission there may be members having experience in fields other than that of members of District Forum, would this imply that the State Commission will be ousted of its Appellate jurisdiction in such complaints. The intention of the legislature is to ensure that the members have the aptitude to deal with consumer problems. It is for the parties to place the necessary material before the forum to deliberate upon. It cannot therefore, be said that since the members of the Consumer Dispute Redressal Agencies do not possess knowledge and experience in medicine, they are incapable of dealing with medical malpractice cases.

d) The Appellant had contended that medical malpractice cases involved complicated question of facts that are not fit for summary trials. Such cases should be kept outside the purview of the Act. The Supreme Court observed that in some cases complicated questions requiring recording of evidence of experts may arise but this was not so in all cases. There are many cases where the deficiency of services is due to obvious faults, as for instance, removal of the wrong limb or performance of an operation on the wrong patient or injecting drug to which the patient is allergic without looking into the out-patient card or the use of wrong anaesthetic or during surgery leaving swabs or other foreign objects inside the patient during surgery. Such issues arising in complaint can be easily established and speedily disposed off by consumer courts. In complaints involving complicated question of facts that require recording of evidence of experts, the consumer forum can ask the complainant to approach a civil court for appropriate relief. The Act clearly states that its provision is in addition to and not in derogation of the provisions of any law for the time being in force.

e) The Supreme Court drew the following conclusions:

i) Services rendered to patient by a medical practitioner (except where the service is free of charge to every patient or under a contract of personal service), by way of
consultation, diagnosis and treatment, both medical and surgical, would fall within the ambit of services as defined in Section 2(1)(o) of the Act

ii) The fact that medical practitioners belong to the medical profession and are subject to the disciplinary control of the Medical Council of India and/or State medical Councils would not exclude the services rendered by them from the ambit of the Act.

iii) Services rendered by a medical officer to his employer under the contract of employment is not ‘service’ under S. 2(1)(o) for purposes of the Act.

iv) Services rendered at private or a Government hospitals, nursing homes, health centres and dispensaries for a fee are ‘services’ under the Act while services rendered free of charge are exempted. Payment of a token amount for purposes of registration will not alter the nature of services provided for free. Services rendered at Government or a private hospitals, nursing homes, health centres and dispensaries where services are rendered on payment of charges to those who can afford and free to those who cannot are also ‘services’ for the purposes of the Act. Hence in such cases the person who are rendered free services are ‘beneficiaries’ under S. 2(1) (d) thereby ‘consumer’ under the Act.

v) Services rendered free of charge by a medical practitioner attached to a hospital/nursing home or where he is employed in a hospital/nursing home that provides free medical facilities, are not ‘services' under the Act.

vi) Where an insurance company pays, under the insurance policy, for consultation, diagnosis and medical treatment of the insurer then such an insurer is a consumer under S.291)(d) and services rendered either by the hospital or the medical practitioner is ‘service’ under S. 2(1)(o). Similarly where an employer bears the expenses of medical treatment of its employee, the employee is a consumer under the Act.

The remedy under Consumer Protection Act is in addition to civil remedy and it cannot be denied to a consumer merely on the ground that either the facts are too complicated or the complainant’s claim is unreasonable.
In *Charan Singh vs. Healing Touch Hospital*,\(^{108}\) the Appellant had brought a claim of Rs. 34 Lakh for removal of one of his kidneys without his consent during the course of the operation, which resulted in the loss of his job and huge expenses for his treatment and upkeep. The National Consumer Commission dismissed his complaint on the reasoning that his claim was excessive, exaggerated and unrealistic. This was because a consumer is required to approach the District, State or National Commission directly depending on the compensation claimed....the complainant was drawing a salary of Rs.3000 plus allowances...This is his allegation, which is not admitted by the opposite party. Even if we accept his contention is correct and even if we accept that as a result of wrong treatment given in the Hospital he has suffered permanent disability, the claim of Rs. 34 Lakh made by the complainant is excessive. We are of the view that this exaggerated claim has been made only for the purpose of invoking the jurisdiction of this commission...

The Supreme Court opined that the quantum of compensation is at the discretion of the Forum irrespective of the claim. The legislative intent behind the Act is to provide speedy summary trial and the Commission should have taken the complaint to its logical conclusion by asking the parties to adduce evidence and rendered its findings on merits. The Court further held,

a. While quantifying damages, Consumer Forums are required to make an attempt to serve the ends of justice so that compensation is awarded, in an established case, which not only serves the purpose of re compensating the individual, but which also at the same time aims to bring about a qualitative change in the attitude of the service provider.

b. It is not merely the alleged harm or mental pain, agony or physical discomfort, loss of salary and emoluments etc. suffered by the Appellant which is in issue here. It is also the quality of conduct committed by the Respondents upon which attention is required to be founded in a case of proven negligence. (para 13, p. 673)

In the case of *Dr. J.J. Merchant vs. Shrinath Chaturvedi*, the Supreme Court observed that in matters involving complicated questions of fact that require recording of evidence, the consumer forum has the discretionary power to direct the complainant to approach civil court for appropriate reliefs. Nevertheless, the procedure provided in the Act is adequate vis-à-vis civil suit to decide medical malpractice cases involving complicated questions of law and fact. For instance affidavits of experts including doctors can be taken as evidence. Thereafter, if cross-examination is sought by the other side and the Commission finds it proper, it can easily evolve a procedure permitting a party who intends to cross-examination to put certain questions in writing and experts including by doctors on affidavit could reply to those questions. In case where the stakes were high and if a party insisted on cross-examining such doctors or experts, there could be video or telephonic conference and at the was argued by the hospital that the parents were not consumers under the Act so could not get any relief. The Court rejected this argument and observed that even parents were covered under the Act and there was nothing in the law which prevented the parents as well as the child from recovering damages. In this case, a child patient was treated for seven days in the Spring Meadows Hospital (Noida) for typhoid. The consultant physician prescribed “Chloromphenical injection”, but the unqualified nurse misread it as “chloroquine” and indented, for the purchase of injection, “Lariago” (i.e. chloroquine). She injected chloroquine 5 mg IV, which was at least 3-1/2times of the normal paediatric dose. The patient suffered irreversible brain damage. Treatment for 21 days in AIIMS, New Delhi, did not help. The patient was compelled to live in a vegetative state.

The National Consumer Commission, whose judgment was confirmed by the Supreme Court, came to the conclusion, that the attending doctor was negligent, as he allowed an unqualified nurse to administer the injection, even though the consultant doctor had advised administration by the attending doctor himself.

The hospital and the nurse were jointly and severally liable. The Court made the following important observations:

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 which under certain circumstances may

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109 MANU/SC/0668/2002
be excusable, but a mistake which may tantamount to negligence cannot be pardoned…. Gross medical mistake will always result in a finding of negligence. Use of wrong drug or wrong gas during the course of anaesthesia will frequently lead to the imposition of liability…. 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 in capable of performing his duties properly.

The Court ordered the following compensation in the case:

(a) Rs. 12.5 Lakh to the child (Rs. 10 Lakh compensation, plus Rs. 2.5 Lakh for equipment).

(b) Rs. 5 Lakh to the parents, for mental agony.

The Supreme Court further held that when a young child is taken to a hospital and treated by the hospital, then

(a) the child’s parents would come within the definition of “consumer”; and

(b) the child also becomes a “consumer”, being a beneficiary of such services.

[Even where the patient is a married daughter, the parents who are required “to spend for her treatment, are also ‘consumers’”, Rajaram S.Parale vs. Dr. Kalpana Desai110]

In the case of Sailes Munja vs. All India Institute of Medical Sciences (AIIMS)111 the hospital claimed that since the treatment was subsidized by the hospital it would not be covered under the Act. The National Commission rejected this argument and held since the treatment was subsidized and not totally free; the hospital would be covered under the Consumer Protection Act. In Ranjit Kumar Das vs. ESI Hospital112 the Complainant’s wife was not given admission to ESI Hospital though the Complainant was registered under the Act. She died and the Complainant was ordered to be paid Rs. 2 lakh as compensation. This case is significant because it

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110 1998 3 CPR 398 (BOM)
111 2004 3 CPR 27 (NC)
112 1998 1 CPR 165 (Cal)
lays down that the ESI hospitals, though government run, are covered under the Consumer Protection Act.

In *Suhas Haldulkar vs. Secretary, Public Health Dept., State of Maharashtra*\(^{113}\) the National Commission held that since the hospital concerned was a Government hospital where patients are treated wholly without charge, a complaint before the Consumer Forum was not maintainable. The Complaint was dismissed since all the patients were treated free of charge but with liberty to the Complainant to approach the civil court. If of course some of the patients were being charged for the services provided, the Court would have had the jurisdiction even if the concerned patient was treated free of charge.

Can the consumer court go into the propriety of the fees charged by a doctor or a hospital? In *B.S. Hegde vs. Dr. Sudhanshu Bhattacharya*\(^{114}\), the State Commission of Maharashtra held the doctor guilty of gross negligence for failure to render necessary post-operative care which was undertaken by him fora consideration (fee). This fee of Rs. 40,000 was paid by cheque a few days after the open-heart by-pass operation performed on the complainant at the Bombay Hospital, for rendering post operative care and treatment for a period of three months. The fee was held to be excessive, unreasonable and unjustifiable though it was conceded that the amount to be charged as fee for medical services was the choice of the medical practitioner. The state commission awarded a sum of Rs. 2 Lakh by way of compensation to the patient. The Complainant approached the Consumer Forum against exorbitant charges levied by the Respondent Cardiologist. Though the National Forum expressed its shock at the charges levelled, it held that it did not have the jurisdiction to go into the propriety of the fees charged by a doctor.

**Civil Negligence and Deficiency in Medical Service**

The substantial aspects of civil liability in negligence cases have, by and large, remained the same over decades with a few additions. The Indian civil law on negligence essentially is the judge made common law followed in England for

\(^{113}\) 1994 3 CPJ 89

\(^{114}\) (1992) CPJ 449
centuries. The main principles have been as laid out in the introduction to this chapter. This section cooks at the application of these principles in concrete situations.

**What are the duties of the doctor towards a patient who approaches him?**

In *Dr. Laxman Balkrishna Joshi vs. Dr. Trimbak Bapu Godbole*\(^\text{115}\) the patient had died due to shock when the Appellant attempted reduction of fracture without taking elementary caution of giving anaesthesia. In the light of the surrounding circumstances it was held that the Appellant was negligent in applying too much of force in aligning the bone. The Supreme Court held that doctors have the discretion to choose the course of treatment to be given and such discretion is relatively large in an emergency case. Nevertheless, the doctor owes his patients a duty of care in deciding whether to undertake the case, his line of treatment to be adopted and a duty in administering that treatment. When a doctor gives medical advice and treatment, he impliedly undertakes that he is possessed of skill and knowledge for the purpose. And in executing his duty he must employ a reasonable degree of skill, knowledge and care.

The Supreme Court also cited with approval the observations in Halsbury Laws of England in its Vol. 30\(^\text{116}\) which state that whether or not he is a registered medical practitioner, such a person who is consulted by a patient owes him certain duties, namely

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

b) Duty of care in deciding what treatment to give;

c) Duty of care in his administration of that treatment; and

d) Duty of care in answering a question put to him by a patient in circumstances in which he knows that the patient intents to rely on his answer.

A breach of any of these duties will support an action for negligence by the patient.

What does a complainant have to prove in order to carry home a charge of medical negligence? The Bombay High Court held that in a claim against medical negligence

\(^{115}\) AIR 1969 SC 128

it was not sufficient to show that the patient suffered in some way. It had to be proven that the suffering or death of the patient was the result of negligence on the part of the doctor. In *Philips India Ltd. vs. Kunju Punnu*\(^1\) the Bombay High Court held that in an action for negligence against a doctor, the plaintiff has to prove:

a) That the defendant had a duty to take reasonable care towards the plaintiff to avoid the damage complained of;

b) That there was a breach of duty on the part of the defendant; and

c) That the breach of duty was the real cause of the damage complained of and such damage was reasonably foreseeable.

In the instant case the deceased was an employee of the Appellant. He approached the resident doctor of the company complaining of a digestive problem and was treated accordingly. After a week he returned, this time complaining of fever, cold and headache. Within four or five days he was brought in with high fever and was kept in the company's dispensary for observation. In the evening when the doctor found red pigmentation on his body he advised pathological tests and was taken to a nursing home of a specialist who treated him for bacteraemia. He approved of the treatment given by the doctor. Later it was discovered that the deceased was suffering from small pox that eventually caused his death.

The issue before the court was whether the doctor was negligent as he failed to diagnose small pox. The court held that a mistaken diagnosis was not necessarily negligent diagnosis. A practitioner can be liable if his diagnosis is so palpably wrong as to prove negligence, in other words, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part regard being had to the ordinary levels of skills in the profession. In the instant case there was no evidence to show that when the patient was taken to the company doctor any doctor of ordinary skill and competence could have diagnosed the disease of the patient as small pox or treated him for small pox. There was no epidemic of small pox at that time to induce the defendant doctor from carrying on test for the same. On the other hand, expert evidence showed that fulminating small pox could have occurred within 24 or 36 hours with no outward manifestations at all and that appearances were very indefinite with no findings on which to base a certain diagnosis. Thus, the defendant

\(^{1}\) 1975 M. L.J. 792
doctor was held to be not negligent. However, what is most important about this case is that the court held that just because a doctor is employed by a company to treat its employees, his responsibility is neither higher nor lower than that of an ordinary doctor.

In some circumstances, however, negligence may be attributed to a medical practitioner without proof of direct nexus between injury and conduct of the practitioner. In *Poonam Verma vs. Ashwin Patel* \(^{118}\) Respondent No. 1 was a registered homeopathy doctor who prescribed allopathic medicine for viral fever, which were prevalent in the Appellant’s locality. The condition of the Appellant’s husband deteriorated and he was admitted in Respondent No.2, a nursing home, for pathological tests and diagnosis. The deceased was treated for two days and as his condition did not improve he was shifted to another hospital where he died within hours of admission. In appeal the Supreme Court set up an ad hoc medical board to determine the cause of death. The board concluded that it was impossible to determine the true cause of the death. Therefore, claims against Respondent No.2 hospital were set aside but Respondent No.1 was held negligent on the ground that he was a homeopathic doctor and was not qualified to administer any other system of medicine. Respondent No.1 was held to be negligent per se.

*In Shyam Sunder vs. State of Rajasthan*, \(^{119}\) the doctrine of *res ipsa loquitur* was again discussed. The normal rule is that it is for the plaintiff to prove negligence, but, in some cases, considerable hardship is caused to the plaintiff, as the true cause of the accident is not known to him, but is solely within the knowledge of the defendant who caused it. The plaintiff can prove the accident but cannot prove how it happened (so as) to establish negligence on the part of the defendant. This hardship is sought to be avoided, in certain cases, by invoking the principle of *res ipsa loquitur*, where the thing is shown to be under the management of the defendant or his servants, and the accident is such, as, in the ordinary course of things, does not happen if

\(^{118}\) (1996) 4 SCC 332

\(^{119}\) AIR 74 SC 876
those who have the management use proper care, then it affords reasonable evidence, in the absence of an explanation by the defendant, that the accident arose from want of care.

In Jasbir Kaur vs. State of Punjab \(^{120}\) the Petitioner’s newborn child’s eye was gouged out by a cat that crept into the ward. The infant was kept in a separate room under the charge of the Petitioner’s relatives, as there was a shortage of cots. It was contended by the Respondent Government hospital that the incident took place because of the Petitioner’s relative’s negligence in leaving the child alone. The Court applied the doctrine of \textit{res ipsa loquitur} and held the hospital and State negligent. The safety and protection was under the control of the hospital and such an incident would have not have occurred in the ordinary course of things but did so, only because of the negligence of the hospital.

What happens when there is a difference of opinion amongst experts concerning the line of treatment to be adopted? In Vinitha Ashok vs. Lakshmi Hospital \(^{121}\) 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. In Kerala removal of uterus was recommended for tackling excessive bleeding in case of cervical pregnancy, and in the instant case the Respondent had to resort to it to save the Appellant’s life. The Supreme Court, thus, held that the course adopted by the Respondent doctor was reasonable and although the risk involved might have called for further investigation, the Respondent doctor’s view could not be dismissed as being illogical. A difference of opinion

\(^{120}\) AIR 1995 P&H 278

\(^{121}\) (2001) 8 SCC 731
amongst experts on procedure adopted by a doctor cannot be called negligence if the procedure adopted is commonly in practice in an area.

A totally free treatment in a place which gives free treatment to everybody may not entitle the complainant to approach the Consumer Court. But he would still be entitled to approach the District Court by filing a suit for damages. In S. Mittal vs. State of U.P. the Court was concerned with negligence in eye camps. An eye camp was organized for extending expert ophthalmic surgical treatment to patients of a particular place in Uttar Pradesh. The operated eyes of several patients were, however, irreversibly damaged, owing to post-operative infection of the “intra ocular cavities of the eyes”, caused by normal saline used at the time of surgery. A public interest litigation was filed, praying (apart from other relief) for compensation to victims for negligence in the arranging of the eye operations. The Supreme Court directed the State Government to pay Rs. 12,500 compensation to each victim (in addition to Rs.5, 000 already paid). The Supreme Court observed that (a) It was no defence, that the treatment was gratuitous or free. (b) The State Government would be liable for negligence in such activities.

_in Eby Minor vs. GEM Hospital_, a newborn child developed gangrene because of which his hand below the elbow had to be amputated. He was a new born premature child placed in an incubator in the Respondent hospital. The National Commission found that there could have been no cause for gangrene except infection which could only have been contacted due to the negligence of the hospital. A compensation of Rs. 1, 00,000 was awarded.

Does the non-conduct of necessary pre-operative tests amount to negligence? This was the issue before the National Commission in Dr.Kaligoundon vs. N. Thangamuthu. The Complainant’s wife had gynaecological problems in terms of excessive bleeding. She was operated upon and her uterus removed. After this, she complained of giddiness and vomiting and died. The death certificate gave the cause of death as renal failure and septicaemia. The National Commission found the doctor

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122 (1989) 3 SCC 223  
123 2004 3 CPJ 37  
124 2004 3 CPJ 29 (NC)
guilty of negligence on the ground that despite there being no urgency in undertaking the surgery no tests were conducted prior to the surgery to assess renal functioning. Similarly, in *S.V. Panchori vs. Dr. Kaushal Pandey*[^125] the Commission held that omission to do a routine investigation constitutes deficiency in service.

The other issue which the Courts have been concerned with relates to the use of medical literature in dealing with medical negligence cases. Can such literature be used to prove or disprove the findings of negligence? In *P.Venkatalaxmivs. Dr. Y. SavithaDevi*[^126], the National Commission observed that the ground reality was that rarely did doctors testify against doctors and therefore there was nothing wrong in using medical literature for determining a case.

Can a hospital be held guilty of negligence if it does not have adequate infrastructure? In *T. Vani Devi vs. Tugutla Laxmi Reddy*,[^127] the Complainant’s wife died in the nursing home where she was admitted for delivery. When she started bleeding no proper care was taken. The National Commission found that the nursing home was not equipped to deal with emergencies nor it had any arrangements to deal with emergencies and as such was guilty of negligence. The Consumer Forum has, however, held that if beds are not available in a hospital, refusing admission to the patient does not amount to deficiency in service. In *Bhajan Lal Gupta vs. Mool Chand Kharati Ram Hospital*[^128] when the patient was refused admission and asked to go to another hospital due to non-availability of beds, the National Forum held that this did not amount to deficiency in service.

The issue of informed consent has been much litigated in foreign jurisdictions. The National Commission was confronted with this issue in the case of *Dr. P.S. Hardia vs. Kedarnath Sethia*.[^129] The Complainant lost his eye due to a surgery which was not an emergency surgery. The Court found the doctor negligent on the basis that performed an operation which was totally unnecessary and also held that simply taking signature on a form stating “to treat him at his own risk under expressive

[^125]: 1999 1 CPJ 332
[^126]: 2004 2 CPJ 14 (NC)
[^127]: 2003 1 CPJ 180
[^128]: 2001 1 CPR 70
[^129]: 2004 3 CPJ 19 (NC)
consent" did not absolve the doctor from taking a more detailed and direct consent especially when there was no emergency.

Is a doctor responsible for the negligence of his nurse? In *K.G.Krishnan vs. Praveen Kumar (minor)*, the minor was admitted to a hospital with fever. He was given a paracetomol injection by the nurse in such a way that his right side was paralyzed. The nurse was not joined as a party to the case but the National Commission held that the nurse was the employee of the doctor and as such the doctor was vicariously liable for her negligence and directed the doctor to pay compensation of Rs. 1 Lakh.

Is a hospital liable for the negligence of its doctors? In *Savita Garg vs. Director, National Heart Institute* the Appellant’s husband was admitted to the National Heart Institute and according to the Appellant her husband died due to negligence of doctors and nurses treating him. The National Forum dismissed her case as she had not joined the treating doctors and nurses as parties to the case. She approached the Supreme Court. The Supreme Court, in this landmark decision held the following:

- It was not necessary to join the treating doctors or nurses as parties as long as the hospital was made a party
- Only the initial burden of proving negligence is on the Complainant. After this,
- it would be for the hospital to show from records, etc. as to what care and treatment were given. It is for the hospital to satisfy that there was no lack of care or diligence.
- The hospital is responsible for the acts of their permanent staff as well as staff whose services are temporarily requisitioned for the treatment of patients.

The Supreme Court remitted the case back to the National Forum for trying it on merits.

Does the failure to monitor dosage of drugs amount to negligence? In *Mohd. Ishfaq vs. Dr. MartinD’souza* the patient was put on haemodialysis and was asked to undergo a kidney transplant. He was administered Amikacin 500 mg injections twice

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130 2003 2 CPJ 125
131 2004 8 SCC 56
132 2002 2 CPR 151
a day for 10 days at the end of which he lost his hearing totally. The National Commission held that it was the responsibility of the hospital to monitor the patient and modify the dosage as per the available literature and failure to do so amounted to negligence. The patient was ordered to be paid Rs. 4 Lakh as compensation for treatment and Rs. 2 Lakh towards the mental agony suffered by him.

Can a doctor charge for facilities he does not offer? In R.M. Joshi vs. Dr. P.B. Tahilramani\textsuperscript{133} the State Commission ordered the recovery of bed charges when the patient was made to sleep on a table amounted to deficiency in service. Can a doctor be charged for performing a surgery, which is not necessary? In Uttaranchal Forest Hospital Trust vs. Smt. Raisan\textsuperscript{134} the complainant’s organ was removed. When the organ was sent for diagnosis no cancer was found. The State Commission found the doctor guilty of negligence for performing a surgery that was wholly unnecessary.

Does the failure of a procedure undertaken by a doctor imply that he was negligent? The Supreme Court has categorically said no. In State of Punjab vs. Shiv Ram\textsuperscript{135} the Supreme Court was dealing with a case where sterilization had failed and the woman gave birth to a child. This was in a State hospital. The State argued that there was always a small chance of failure in such procedures and the failure of sterilization did not mean that the doctor was negligent. The Supreme Court upheld this argument and cited with approval a decision of the English Court in Eyre vs. Measday\textsuperscript{136} in which the Court had observed,

In the absence of any express warranty, the Court should be slow to imply against a medical man an unqualified warranty as to the results of an intended operation, for the very simple reason that, objectively speaking, it is most unlikely that a responsible medical man would give a warranty of this nature.

\textsuperscript{133} 1993 3 CPR 435 (Bom)

\textsuperscript{134} 2004 1 CPJ 257

\textsuperscript{135} (2005) 7 SCC 1

\textsuperscript{136} 1986 1 ALL ER 488
REVIEW OF JUDICIAL PRONOUNCEMENTS IN INDIA

A review of Indian decisions on medical negligence would be relevant in this regard. In *John Oni Akerele v. The King*[^137^], a duly qualified medical practitioner gave to his patient the injection of Sobita which consisted of sodium bismuth tartrate as given in the British Pharmacopoeia. However, what was administered was an overdose of Sobita. The patient died. The doctor was accused of manslaughter, reckless and negligent act. He was convicted. The matter reached in appeal before the House of Lords. Their Lordships quashed the conviction and summed up the position as under,

- That a doctor is not criminally responsible for a patient's death unless his negligence or incompetence went beyond a mere matter of compensation between subjects and showed such disregard for life and safety of others as to amount to a crime against the State.
- That the degree of negligence required is that it should be gross and that neither a jury nor a court can transform negligence of a lesser degree into gross negligence merely by giving it that appellation. There is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime.
- It is impossible to define culpable or criminal negligence, and it is not possible to make the distinction between actionable negligence and criminal negligence intelligible, except by means of illustrations drawn from actual judicial opinion. The most favourable view of the conduct of an accused medical man has to be taken, for it would be most fatal to the efficiency of the medical profession if no one could administer medicine without a halter round his neck.

The question of degree has always been considered as relevant to a distinction between negligence in civil law and negligence in criminal law. In *Kurban Hussein Mohamedalli Rangawalla v. State of Maharashtra*[^138^] while dealing with Section 304A of IPC, the following statement of law by Sir Lawrence Jenkins in *Emperor v. Omkar Rampratap*[^139^] was cited with approval.

[^137^]: AIR 1943 PC 72.
[^138^]: indiankanoon.org/search/?formInput=state%20of%20karnataka
[^139^]: 4 Bom LR 679,
"To impose criminal liability under Section 304-A, it is necessary that the death should have been the direct result of a rash and negligent act of the accused, and that act must be the proximate and efficient cause without the intervention of another's negligence. It must be the causa causans; it is not enough that it may have been the causa sine qua non."

The above said view of the law has been generally followed by High Courts in India. The same view has been reiterated in *Kishan Chand &Anr. v. The State of Haryana*.\(^{140}\)

In, *Juggankhan v. The State of Madhya Pradesh*\(^{141}\), the accused, a registered Homoeopath, administered 24 drops of stramonium and a leaf of dhatura to the patient suffering from guinea worm. The accused had not studied the effect of such substances being administered to a human being. The poisonous contents of the leaf of dhatura were not satisfactorily established by the prosecution. The Supreme Court exonerated the accused of the charge under Section 302 IPC. However, on a finding that stramonium and dhatura leaves are poisonous and in no system of medicine, except perhaps Ayurvedic system, the dhatura leaf is given as cure for guinea worm, the act of the accused who prescribed poisonous material without studying their probable effect was held to be a rash and negligent act. It would be seen that the profession of a Homoeopath which the accused claimed to profess did not permit use of the substance administered to the patient.

The accused had no knowledge of the effect of such substance being administered and yet he did so. In this background, the inference of the accused being guilty of rash and negligent act was drawn against him. Thus the principle which emerges is that a doctor who administers a medicine known to or used in a particular branch of medical profession impliedly declares that he has knowledge of that branch of science and if he does not, in fact, possess that knowledge, he is prima facie acting with rashness or negligence.

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\(^{140}\)(1970) 3 SCC 904.

\(^{141}\)(1965) 1 SCR 14
Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole and Anr\textsuperscript{142} was a case under Fatal Accidents Act, 1855. The duties which a doctor owes to his patients came up for consideration. The Supreme Court held that a person who holds himself ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for that purpose.

In *Poonam Verma v. Ashwin Patel and Ors*\textsuperscript{143} a doctor registered as medical practitioner and entitled to practice in Homoeopathy only, prescribed an allopathic medicine to the patient. The patient died. The doctor was held to be negligent and liable to compensate the wife of the deceased for the death of her husband on the ground that the doctor who was entitled to practice in homoeopathy only, was under a statutory duty not to enter the field of any other system of medicine and since he trespassed into a prohibited field and prescribed the allopathic medicine to the patient causing the death, his conduct amounted to negligence per se actionable in civil law.

In *Achutrao Haribhau Khodwa and Ors. v State of Maharashtra and Ors*\textsuperscript{144} the Supreme Court noticed that in the very nature of medical profession, skills differ from doctor to doctor and more than one alternative course of treatment are available, all admissible. Negligence cannot be attributed to a doctor so long as he is performing his duties to the best of his ability and with due care and caution. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession. It was a case where 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 fastened on the surgeon because no valid explanation was forthcoming for the mop having been left inside the abdomen of the lady. The doctrine of res ipsa loquitur was held applicable 'in a case like this'.

\textsuperscript{142}1969)1 SCR 206
\textsuperscript{143} (1996) 4 SCC 332
\textsuperscript{144} (1996) 2 SCC 634
In, *Dr. Suresh Gupta v. Govt. of NCT of Delhi and Anr*\(^{145}\), the legal decision is almost firmly established that where a patient dies due to negligent medical treatment of the doctor, the doctor can be made liable in civil law for paying compensation and damages in tort and the same time, if the degree of negligence so gross and his act was reckless as to endanger the life of the patient, he would also be made criminally liable to offence under Section 304-A IPC. "Thus a doctor cannot be held criminally responsible for patient's death unless his negligence or incompetence showed such disregard for life and safety of his patient as to amount to a crime against the State".

In the case of *Jacob Mathew v. State of Punjab*, three Judge Bench of Supreme Court by order quashed prosecution of a medical professional under Section 304-A/34 IPC and disposed of all the interlocutory applications that doctors should not be held criminally responsible unless there is a prima-facie evidence before the Court in the form of a credible opinion from another competent doctor, preferably a Government doctor in the same field of medicine supporting the charges of rash and negligent act.

The result of all these decisions based on civil and criminal approaches can be summed as

(1) 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. 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'.

(2) Negligence in the context of 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.

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\(^{145}\) MANU/SC/0579/2004
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. When it comes to the failure of taking precautions what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence.

(3) A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices.

(4) The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of mens rea must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.

(5) The word 'gross' has not been used in Section 304A of IPC, yet it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be 'gross'. The expression 'rash or negligent act' as occurring in Section 304A of the IPC has to be read as qualified by the word 'grossly'.

(6) To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

(7) *Res ipsa loquitur* is only a rule of evidence and operates in the domain of civil law especially in cases of torts and helps in determining the onus of proof in actions relating to negligence. It cannot be pressed in service for determining per se the
liability for negligence within the domain of criminal law. Res ipsa loquitor has, if at all, a limited application in trial on a charge of criminal negligence. In comparison to Criminal Negligence, that needs to be defined as gross negligence, the medical negligence under Consumer Protection Act does not require mens rea to be proved. Sometimes the simplification of judicial process under CPA can be equated to res ipsa loquitor.

There is complaint procedure under Medical Council Regulations. A patient can complain to the Medical Council of India in relation to alleged medical negligence seek an action taken against the medical professional. The details of the Medical Council Regulations are as follows.

2.7 Medical Council of India Regulations

The code of ethics for medical professionals adopted by the Indian parliament as a part of the Medical Council Act, governs the conduct of the medical professionals in their medical work, in their economic activity and with regards to their relationship with other professionals and the society at large. Medical ethics, particularly those related to medical practice and societal responsibility, are essentially formulated on the basis of the justice theory developed by the moral philosophers. There are four principles, which form the fundamentals of justice theory as applied to the medical care. They are as follows:

- Principle of non-malfeasance: It is also summed up in the axiom, first do no harm, or that the medical intervention should not cause harm to the patient seeking care.

  - Principle of beneficence: This principle stipulates that the medical intervention not only should not harm, but should also be intended for the benefit of the patient.

  - Principle of autonomy: This principle has developed to its fullest extent only in last quarter century and has replaced what was earlier called 'medical paternalism'. It is also in harmony with the liberal democratic ethos of individual liberty and choice. Essentially it means that the patient is an independent individual and any medical intervention should be done only after full information is given and the patient has expressly consented for such an intervention. This also gives the patient a right to make choice as to what kind of medical intervention is best suited for him or her.

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146 See Annexure IV
Principle of justice: This principle makes it clear that the doctors are responsible to the society and that they must follow the non-discriminatory way of medical practice.

The professionals do face ethical dilemmas in day to day medical practice. These dilemmas are sought to be resolved, in a case to case basis, by weighing each principle as applicable to the situation.\footnote{Aditi Iyer&Amar Jesani,Medical ethics for self-regulation of medical profession and practice, 2004, CEHAT, pp.7}

In a study aimed to assess the knowledge of, and attitudes to, medical ethics among doctors in the Kalinga Institute of Medical Sciences (KIMS), Bhubaneswar, Orissa. A self-administered structured questionnaire was administered to 120 practitioners and it was found that, there was lack of proper and detailed knowledge on the MCI’s Code of Ethics among doctors in KIMS, though a little more than half of them had read it once or partially. There is a need to sensitise them to the Code of Ethics and to medical ethics in general. A test on the code at the time of registration could be considered. The medical ethics; acts related to medical practice should be emphasized in the MBBS under graduate so also in post graduate syllabus and examinations. There is always a continuum between practice and education because a medical career is one of life-long learning. Medical ethics teaching and training should help the doctors at any level whatever may be the discipline to assimilate and conceptualize the basic principles of ethical reasoning. The application of ethics to medical practice dates back to ancient civilization as even today, all medical graduates must swear symbolic adherence to the Hippocratic Oath. Codes of conduct and laws regulating the profession are laid down from time to time. The periodical CME programme in medical ethics should be mandatory for all practitioners.\footnote{Shreemanta Kumar Dash, Medical Ethics, Duties & Medical Negligence Awareness among the Practitioners in a Teaching Medical College, Hospital-A Survey;2010,J Indian Acad. Forensic Med, 32(2),p.155}

The Code of Medical Ethics as described by the Medical Council of India in 2002, states that the medical professional should maintain good medical practice. Chapter 1.2.1 says that, the Principal objective of the medical profession is to render service to humanity with full respect for the dignity of profession and man. Physicians should
merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion. Physicians should try continuously to improve medical knowledge and skills and should make available to their patients and colleagues the benefits of their professional attainments. The physician should practice methods of healing founded on scientific basis and should not associate professionally with anyone who violates this principle. The honoured ideals of the medical profession imply that the responsibilities of the physician extend not only to individuals but also to society.\textsuperscript{149}

The inherent quality of any professional service depends on its ethical values as imbibed by its professionals.; Every profession has to zealously safeguard its autonomy, and at the same time take appropriate measures to extract professional accountability, in the event that the professional indulges in any kind of professional misconduct. The kind of assurance alone infuses confidence in the minds of the public. Therefore, in this respect, the professional bodies prescribe codes of ethical behaviour, which every professional is expected to adopt and comply with. This is how a professional body, in a democratic way, conceives, prescribes and enforces its code of ethics.\textsuperscript{150}

The Medical Council of India has established a Code of Ethics called the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 for all medical practitioners, which they are bound to follow. This is divided in to 8 chapters. While Chapter 1 to 6 describe Maintaining the good medical practice, duties of physicians to patients, each other and to the paramedics, what constitutes unethical acts; chapter 7 and 8 describe misconduct and punishment and disciplinary action that the medical council can take.

Professional incompetence shall be judged by peer group as per guidelines prescribed by Medical Council of India.\textsuperscript{151}

\textsuperscript{149} Code of Ethics Regulations, 2002, Medical Council of India, Chapter 1.2.1
\textsuperscript{150} S.V JOGA RAO, LAW, MEDICAL ETHICS AND SYSTEMATIC FRAMEWORK: AN OVERVIEW, MEDICAL ETHICS, A READY REFERENCER, 1\textsuperscript{st} edition,2010,Legalaxy Publications, pp. 37
\textsuperscript{151} CONSUMER LAW ARTICLES, March 12, 2007, IndLaw.com, Medical Negligence – How far should doctors be held liable?
The Medical Council of India (MCI) in an amendment to its existing code of conduct, the Indian Medical Council (professional conduct, etiquette and ethics) regulations 2002, has proposed sweeping guidelines on the relationship between the pharmaceutical industry and the medical profession in India.

While discussing the MCI guidelines in relation to allied health care sector industry, Dr. Sanjay Nagral says, it is an attempt at a code of ethical conduct for doctors and professional associations in their relationship with the pharmaceutical and allied health sector industry. The MCI is a quasi-judicial body and its code, though not law is ethically binding on all practitioners of modern medicine in India. It is interesting that a council which is not exactly known for its proactive stance on ethics has chosen to issue one of the most explicit and comprehensive set of rules on this subject. The impact of these guidelines on ground reality remains to be seen but, if recent news items are to be believed, by doing so the MCI has at the least succeeded in breaking the conspiracy of silence that surrounded this area in India. In a sense, the guidelines read like a confessional list of a large number of debatable practices in industry marketing that have become commonplace over the years. The guidelines also cover clinical trials sponsored by the industry, an area of current relevance. Following the initial guidelines, the MCI has now gone a step further by announcing a list of punishments which are graded based on the financial quantum of the gift received. For example, those who have received more than Rs 1 Lakh (Rs 100 000) will be deregistered for more than a year. The MCI claims that this is the first time in the world that quantum of punishment have been specified.152

Maintenance of Medical Records have been a point of discussion and the Medical Council of India, has issued the (Professional Conduct, Etiquette and Ethics) Regulations, 2002, which mentions the following on Maintenance of Medical Records (Section 1.3)

The Existing Medical Ethics Codes and Laws, http://www.indlaw.com/guest/databasesearch/articles/core_articledisplay.asp?id=medical4_focus

Last Accessed Sept 12,2012

• Every physician shall maintain the medical records pertaining to his / her indoor patients for a period of three years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India (Section 1.3.1 and Annexure IV).

• If any request is made for medical records either by the patients / authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours (Section 1.3.2)

• A registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared. (Section 1.3.3 and Annexure IV).

• Efforts shall be made to computerize medical records for quick retrieval. (Section 1.3.4)

The ethical and legal dimensions of the issue of medical negligence, take upper hand while discussing the pros and cons of self regulation of professionals by professional bodies and Medical Council. The medical professional who is ethical, need not be worried about the legal aspects, since he/she follows the ethical guidelines. In other words, the medical professional who follows the ethical guidelines of the Medical Council, is shielded from any legal action being taken by patients.

In response to the changing environment, Code of Medical Ethics has also been subjected to thorough amendments. No doubt, the amended Code itself requires further amendments. Be that as it may, owing to the fact this code is a formal legal document; it is a matter of mandate that it should be enforced meaningfully in a practical context. The present day context clearly reveals he changing landscape of doctor patient relationships. Economics of healthcare delivery seems to be the crucial factor for these developments. A person who is in need of timely health care

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is caught between the issues of accessibility and affordability. Similarly a professional doctor who renders health care service is sandwiched between patient satisfaction and professional accountability. Professions are for the people and not for professionals. Hence, professional accountability must be norm. This is equally applicable to every professional service, not only to the medical profession.\textsuperscript{154}

2.8 International Perspective

Law is a response to societies felt needs. Legislation is enacted to deal with problems the society is facing, or expects soon to face. Likewise, courts deciding cases look beyond the situations and interests of the individuals in the particular litigation and try to reach decisions that will also constitute good public policy. Consequently, studying both legislation and adjudication in a particular field is a way of seeing what problems society is facing or feels it is facing in that area and what it regards as workable solutions.\textsuperscript{155}

“It is so easy to be wise after the event and to condemn as negligence that which is only a misadventure. One ought always to be on one’s guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but those benefits are attended by considerable risks . . . one cannot take the benefits without taking the risks . . . one must insist on due care for the patient at every point, but one must not condemn as negligence that which is only a misadventure.”

Those were Lord Denning’s words in \textit{Roe v Minister of Health}\textsuperscript{156} a particularly sad case in which two men suffered severe injuries as a consequence of being given spinal anaesthetics. The anaesthetic agents were stored in glass ampoules and the ampoules themselves were kept in a solution of phenol. Unknown to anyone and held to be not capable of reasonable discovery - the glass of the ampoules was

\textsuperscript{156} 1954, 2 WLR 915
awed with invisible hairline cracks through which the phenol penetrated, adulterating the anaesthetic agent and thus causing the injuries to these two patients.\footnote{157}

An essential component of an action in negligence against a doctor is proof that the doctor failed to provide the required standard of care under the circumstances. Traditionally the standard of care in law has been determined according to the \textit{Bolam} test. \textit{Chiu Keow v Government of Malaysia}\footnote{158} This is based on the principle that a doctor does not breach the legal standard of care, and is therefore not negligent, if the practice is supported by a responsible body of similar professionals.

- The \textit{Bolam} principle, however, has been perceived as being excessively reliant upon medical testimony supporting the defendant.
- The judgment given by the House of Lords in the recent case of \textit{Bolitho} imposes a requirement that the standard proclaimed must be justified on a logical basis and must have considered the risks and benefits of competing options.

The effect of \textit{Bolitho} is that the court will take a more enquiring stance to test the medical evidence offered by both parties in litigation, in order to reach its own conclusions. Recent case law shows how the court has applied the \textit{Bolitho} approach in determining the standard of care in cases of clinical negligence. An understanding of this approach and of the shift from the traditional \textit{Bolam} test is relevant to all medical practitioners, particularly in a climate that is increasingly litigious.\footnote{159}

In medical litigation, the test for the standard of care in law expected of doctors is based on the principle enunciated in \textit{Bolam}. 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 \textit{Bolitho}, 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

\footnotesize{\textsuperscript{157} John R.Griffith, \textit{CLINICAL NEGLIGENCE IN GENERAL PRACTICE: THE LAW OF NEGLIGENCE}, Edited by Michael Drury 2000, pp.43 \textsuperscript{158} 1967 1 WLR 813 \textsuperscript{159} Ash Samanta and Jo Samanta, 2003, Legal standard of care: a shift from the traditional Bolam test, Clinical MedicineVol.3 No 5 September/October 2003, pp. 443}
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.  

The most accepted expression of the duty principle is the one made by Lord Atkins in the leading case of Donoghue v Stevenson. The plaintiff’s friends bought her a ginger beer in a café, she drank some of it and as she was helping herself to a second glass, the remains of a decomposed snail floated to the top of her glass. The nauseating sight of this and the impurities she already drank resulted in a shock and severe gastroenteritis. The case went all the way to the House of Lords on the preliminary issue as to whether a duty of care existed. The question for the House of Lords to decide was: if a company produced a drink and sold it to a distributor, was it under any legal duty to the ultimate purchaser or consumer to ensure reasonable care that the article was free from defect likely to cause injury to health? Lord Atkins stated.

The English law states that there must be and is, some general conception of relations given rise to a duty of which the particular cause found in the books are but instances. He went on to lay down the basis of the present law in the “neighbour” principle in this much-quoted passage:

“The rule is, you are to “love your neighbour” and the lawyer’s question saying ‘who is my neighbour’, receives a restricted reply. You must take 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 a person who is so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I was directing my mind to the acts or omission which is called in question”.

160Id. pp. 446
This statement suggests the existence of a general duty of care towards anyone who is likely to suffer injury through the defendant's careless conduct. Even though the rule was propounded in the context of a manufacturer/consumer relationship, it is applied as a general principle beyond the initial context in which it was propounded. This text has proved the foundation upon which countless cases of alleged negligence have been tried and still continue to be judged.\textsuperscript{161}

\textit{Bolam v Friern Hospital Management Committee}\textsuperscript{162} is an English tort law case that lays down the typical rule for assessing the appropriate standard of reasonable care in negligence cases involving skilled professionals (e.g. doctors): the "Bolam test". Where the defendant has represented him or herself as having more than average skills and abilities, this test expects standards which must be in accordance with a responsible body of opinion, even if others differ in opinion.

Bolam test:
1. Firstly, it must be established that there is a duty of care (between a doctor and patient this can be taken for granted).
2. Second, it must be shown that the duty of care has been breached. This is where the Bolam test is relevant, because falling below the standard of a responsible body of medical men means that person will be considered negligent.
3. Third it must be shown that there was a causal link between the breach of duty and harm.
4. And fourth, it must be shown that the harm was not too remote.\textsuperscript{163}

Health professionals, politicians, and media commentators are rarely in agreement, except when it is to cite a “culture of blame” as the greatest cause of litigation in medical error today. Yet, few stop to question the cultural tableau of doctor, patient, and lawyer, or reflect on what current medical jurisprudence means for the practice of medicine. Blame is the sole form of redress and the legal counterpoint between aggrieved doctors and patients in most developed countries. Like it or not, lawyers,

\textsuperscript{161}Eric Okojie, Professional Medical Negligence in Nigeria, 1994, www.nigerianlawguru.com/\ldots/PROFESSIONAL\%20MEDICAL\%20NEG
\textsuperscript{162}[1957] 1 WLR 583
\textsuperscript{163} Supra
doctors, and patients have all played leading roles in the history of medical negligence.¹⁶⁴

Most countries have, eventually, arrived at a similarly confrontational and definitive legal process of dealing with medical negligence, usually some variant of tort in medical jurisprudence. Yet the social and historical processes that have contributed to the development of medical malpractice and, perhaps more importantly, what one define as medical negligence are little known. Medical negligence, I would suggest, 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, medical practice, health professionals, and patients.

In common with other contemporary nations, the USA had a brief flirtation with contract law in the 19th century. However, jurisprudence sat uneasily with the unequal doctor-patient relationship; patients could not be expected to understand medical nomenclature or esoteric diagnosis and regimen. Additionally, 19th-century US physicians baulked at the thought of being held in the same regard as tradesmen. This echoes a similar anxiety about professional status across Europe and its colonies in this period. However, in post-revolution North America, elitism was frowned upon and there, more than anywhere else, the medical profession struggled for harder and longer to establish itself into a completely amalgamated profession. Revolution also brought individual liberties and rights that, together with a decline in religious fatalism, led to a great number of medical lawsuits in 19th century North America. Lawyers there saw medical malpractice lawsuits as a source of wealth, which further exacerbated the burgeoning malpractice crisis. When, finally, the US medical profession united and raised professional standards, patients’ expectations of the acceptable standard of care went up concomitantly. Inevitably, physicians sought liability insurance: mitigating their individual risk but rendering each and every insured medical professional a financially worthy prospect for medical litigation.

The trajectory of medical negligence in the USA contrasts with the British experience, where it is difficult to hold on to one conception through time. Within

modern history, I would argue that there are at least six distinct periods. Each period offers different notions of what negligence has meant in the past and hints how different it may be again, in the future. During the 18th century until the mid 19th century, patients had a commanding role: they had a great deal of control over diagnosis, the law governing negligence claims, and the contractual process between patient and doctor. Then from the mid-19th century to the end of that century doctors began to gain the upper hand through advances in diagnosis, knowledge, skill, technical innovation, and, particularly, professionalization. However, patients retained the upper hand in law; medical negligence was viewed very much under the light of a trade contract. For the first half of the 20th century, new acts in national insurance, pension rights, state doctoring, and voting brought doctors closer to the state. There were many developments in state medicine, welfare, and public health. In English law, doctors were also beginning to gain the upper hand; the law increasingly viewed doctors' negligence as something apart from regular trade negligence. The decades leading up to the 1980s could be regarded as perhaps a “golden age” for doctors in the UK. During the 1950s, developments in the National Health Service (NHS) and English courtrooms led to the infamous “Bolam” precedent in 1957, which was a landmark judgment, empowering doctors within tort law. From then, doctors had complete power of diagnosis and they essentially governed the law of medical negligence. Patients had fewer rights in law, diagnosis, and policy than ever before. From the 1980s to the end of the 20th century, the Conservative government began the gradual introduction of privatization into the NHS, a trend that was continued under Labour. Competition entered the NHS and (some commentators argue) so did an increase in patients' expectations. Doctors retained the power of diagnosis, and, essentially, were self-regulating in medical negligence law. Despite this, medical negligence claims increased. Ethical issues, human rights, patients’ rights, and consumer expectations converged during this time to exacerbate an increased use of litigation in cases of medical negligence. In the 21st century, there have been even greater calls for patients' rights. Although doctors have retained the power of diagnosis, there has been greater participation from the lay public in ethical and health-administrative considerations.

Movement from Bolam to Bolitho:
The “Bolam” precedent has come under increasing pressure in the law courts, leading to the “Bolitho” decision, whereby juries, in exceptional cases, are theoretically allowed to judge between medical experts, although, essentially, changing nothing in practice from “Bolam”.  

The case summary of Bolitho is as follows,

Patrick Bolitho, plaintiffs son, at the age of two had been detected with a patent ductus arteriosus, a respiratory disorder, a surgery, in 1983 had been conducted to correct this anomaly from which Patrick recuperated well. A year later he was admitted to St. Bartholomew’s hospital with cough disorder. He was placed under the care of Dr. Horne According to the nurse at duty then, she did not see the patient when she asked her to do so. Again on second occasion Dr. Horne delegated the care to another doctor, Dr. Rodger, her junior. Dr. Rodger too did not see the patient. This led to deterioration of patient’s health leading to brain damage from which he subsequently died.

It was contented by the experts from the plaintiff’s side that had the doctor attended the patient and intubated the patent on time, the patient could have been saved. To this the response of the defendant was that had she attended the patient she would not have attempted intubation and also cited Bolam to demonstrate that a responsible body of opinion would have agreed with her. So, hypothetically, the consequence would have been the same even if she had attempted intubation.

The court was of the opinion that there has to be a logical basis for the opinion not to intubate. A judge will be entitled to choose between two bodies of expert opinion and to reject an opinion which is 'logically indefensible'. This has been interpreted as being a situation where the Court sets the law not the profession. However, Lord Browne Wilkinson held that the court would hold a practice that was in conformity with a sound body of expert opinion to be negligent only in "a rare case". On the facts, it was decided that not intubating the child in the particular circumstances at

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165 Supra Note 110
166 Bolitho v city and Hackney Health Authority (1998) AC, 232.
hand was not a negligent way to take, even though the expert opinion on the matter was divided.

The “Bolam test” means that today under English law the medical profession sets its own standard of medical care. This, more than anything else, has led to an awkward juxtaposition for historians assessing negligence in the UK before and after the mid-20th century. Since Bolam, modern medical negligence law can be whittled down to three fundamental factors: one, confirming the patient was “owed a legal duty of care” by the health practitioner who is the “defendant” in cases of medical negligence; two, establishing that the defendant was in “breach” of that duty of care in failing to reach the standard of care required by law; three, proving that this breach of duty caused or contributed to the damage or injury to the patient. Establishing causation was always central to negligence law in history, but the approaches, theories, and methods to establish it have changed through time. Since Bolam, “reasonable practice” by a reasonable practitioner is used in law to establish what the standard of care is and if this had been breached and, consequently, if the breach was a causal factor in the outcome. Crucially, the by product of a “standard of care” was that patients' rights moved to the centre of medical negligence. This provides us with an interesting prism to observe the past.167

There are a number of difficulties with the Bolam test which still apply asymmetrically in negligence cases, mainly to the advantage of the defendant doctor, or health authority; it is often too easy to invoke Bolam on the basis of single expert's opinion, and conversely too difficult for the claimant to show that no other doctor could have acted similarly.

As a measure of liability, Bolam gives weight to what medical practice is (or what contemporary practice was) rather than what practice should be. So instead of upholding the standard of care that is good, Bolam defaults to the standard of care that can be supported, even if it falls below what is objectively acceptable. Consequently, the court has little discretion to decide what is standard of care should have been considering all circumstances of a particular case; there is no

167 Supra Note 110
option to prefer one expert’s opinion over the other, the choice is all or nothing—can the action be supported or can it not?

_Bolam_ therefore criticized as a clumsy tool, born out of medical nepotism and implemented through a system of peer review, where doctors set the standards required of them and give testimony in each other’s defence. Under Bolam, Doctors and defence organizations enjoy a degree of protection that validates and perpetuates outdated medical practice simply because that practice remains entrenched in some doctors.\(^{168}\)

**Daubert is another point in evidence**

The 1993 U.S. Supreme Court’s decision in _Daubert v Merrell Dow Pharmaceuticals_ established a new “Daubert standard”.\(^{169}\) The case summary is as follows.

Two boys, Jason Daubert and Eric Schuller, were born with serious defects after their mothers took the anti-nausea drug Bendectin while pregnant. When the boys sued Merrell Dow, the manufacturer of Bendectin, alleging that the drug caused their defects, they became part of a lengthy line of similar plaintiffs making similar allegations: During the 1980s, there were upwards of 1700 suits claiming that Bendectin had caused birth defects in the children of mothers who took the drug while pregnant. When disputes over the admissibility of expert testimony landed the case in the United States Supreme Court.

The district court ruled that this data was not admissible. Drawing on the Frye standard for evaluating the validity of expert testimony, the court rejected the reinterpretations of Bendectin data because they had been prepared expressly for the case and had not been peer reviewed, and rejected the other studies because they attempted to make epidemiological claims in the absence of epidemiological data. Summary judgment was granted to Merrell Dow.

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\(^{168}\) Christopher Stone, 2011, _From Bolam to Bolitho: unraveling medical protectionism_. [www.medicalandlegal.co.uk/.../From-Bolam-to-Bolitho-unraveling](http://www.medicalandlegal.co.uk/.../From-Bolam-to-Bolitho-unraveling)

\(^{169}\) _Daubert v. Merrell Dow Pharmaceuticals_ 509 U.S. 579 (1993)
The 9th Circuit affirmed the district court's decision to exclude the studies that formed the basis of the plaintiffs' case. The Supreme Court agreed to hear Daubert because it recognized the necessity of clarifying the proper criteria for admissibility of expert testimony. At issue was whether the adoption of Federal Rules of Evidence trumped the Frye standard that was so decisive in this case, and whether Rule 702, which addresses the issue of scientific evidence, supersedes Frye.

The Court found that the Federal Rules of Evidence do indeed trump Frye. In an opinion that closely followed the reasoning of Atlantic Legal's brief, the Court explained that Rule 702's stipulation that expert testimony must be "scientific ... knowledge" is closely grounded in an assumption that such "knowledge" is distinct from speculation, and can only be derived from proper scientific methods and procedures. The Court went on to dismantle the misguided briefs filed on behalf of petitioners, drawing extensively on Atlantic Legal's explanation of why and how those briefs had confounded the difference between how science and the law assess and pursue truth.

This new standard encouraged judges to assume a more active “gatekeeper” role by not only examining the validity of the underlying science more rigorously, but also examining the methodology used by the expert in applying the science to the specific case. In particular, the court opinion recommended four straightforward guidelines for judges to consider when examining the merits of the testimony.

1. Whether the expert's technique or theory can be or has been tested.
2. Whether the theory has been subject to peer review and publication.
3. The known or potential rate of error of the technique or theory.
4. Whether the theory or technique has been generally accepted in relevant field.170

Ongoing development of medicine as a scientifically grounded practice reveals that the medical profession shares much with the legal profession. Science-based medical evidence and the Daubert trilogy reflect orchestrated parallel movements in medicine and law about how to assess expertise critically. Although neither has paid any attention to the other, both movements recognize that professional

education and training are necessary but not sufficient to assure expertise. Expertise, in the vision of both science-based medical evidence and the Daubert trilogy, begins but does not end with the question of qualifications. A medical expert’s qualifications provide no assurance of the reliability of the expert's methods and procedures. Beyond both professions independently drawing this distinction, the impact of distinguishing qualifications and expertise in medicine and law is also of consequence. Why has the recognition of this distinction not transformed the practice of medicine or law?¹⁷¹

Science-based medical evidence and the Daubert trilogy reveal much about the nature of both professions. Just as the promulgation of myriad clinical practice guidelines that claim to rest on a critical examination of the medical research literature has not precipitated a sea change in medical practice, so the Daubert trilogy's pronouncements about the admissibility of expert testimony that claims to rest on a critical examination of expertise has not precipitated a sea change in legal practice. The attitudes and beliefs of attorneys about the conduct of trials have not been fundamentally changed overnight by the Daubert trilogy any more than the attitudes and beliefs of physicians about the practice of medicine has been changed overnight by the emergence of clinical practice guidelines. The practices of both professions are determined by myriad intersecting forces that are resistant to sudden change. Charles Darwin's observation about the process of change in natural selection also captures the essence of this process of change in professional practice.¹⁷²

In the well-researched paper The Role of Clinical Guidelines in Medical Negligence Litigation: A Shift from the Bolam Standard ¹⁷³ the academic writers suggest a fourfold test:-

“(a) is it Bolam-defensible, (b) is it Bolitho-justifiable, (c) is it Daubert-valid, and (d) how does it apply to the particular circumstances of the matter in question (case-specific application)?”¹⁷⁴

¹⁷² Id
¹⁷³ Supra note 110
¹⁷⁴ Ian McLellan, Does Bolitho (Bolitho v City & Hackney HA [1997] 4 All ER 771) eclipse Bolam (Bolam v Friern Hospital Management Committee [1957] 1 WLR 582) September, 2007.
The above article discusses the four tests being applied in US for Clinical Guidelines litigation. The decision of such cases depends on the answers to the above four tests.

**Why Opt for Negligence (Rather than Strict Liability)?**

The negligence rule conveys more of the information required by the market in order to resolve its inherent incomplete information problems, i.e., the moral hazard and adverse selection problems. It serves this legal function by creating a mechanism motivating both parties to any potential lawsuit to invest in seeking and assessing the information they require in order to file or defend against a lawsuit. The negligence rule ensures a very high correlation between the information required for filing and defending against lawsuits and the information required by the market to resolve its inherent moral hazard and adverse selection problems; the judicial process requires both parties to disclose the relevant information. Moreover, any negligence claim requires the court to inquire into questions relevant for conveying the information required by the market. During a trial, the court would inquire whether the doctor acted optimally, including maintaining professional expertise, and whether the MCO (Managed Care Organization in US) acted optimally, including the selection of appropriate medical gear, maintaining an appropriately skilled medical staff, overseeing that staff and determining appropriate medical procedures. The court would expose the routine work methods of the doctor and her employing organization, focusing on their actions pertaining to the case in question. Thus, through the negligence mechanism, the court would convey invaluable information to the market, focused on disclosing the hidden actions and qualities of both the doctor and the HMO (Health Maintenance Organization in US). Where the market “knows” that such information would one day be disclosed, it would be able to rely on presentations by the doctor and the MCO *ex ante* and to trust them to act optimally. Conversely, the strict liability mechanism dispenses with those inquiries and therefore conveys much less information to the market. Without the information or a reliable threat that the information will eventually be conveyed to the market, the
equilibrium in which the public relies *ex ante* on the doctor's and HMO's presentations, to the effect that they have acted optimally, will simply not exist.\textsuperscript{175}

### The feasibility of criminal sanction

Criminal sanction is as an indiscriminate prosecution of medical professionals for criminal negligence is counter-productive and does no service or good to the society. There must be a link between fault, blame and justice requirements, significance and relevant to the issues before us are:

- The social efficacy of blame and related sanctions in particular cases of deliberate wrongdoings may be a matter of dispute, but their necessity in principle from a moral point of view, has been accepted. Distasteful as punishment may be, the social, and possibly moral, need to punish people for wrongdoing, occasionally in a severe fashion, cannot be escaped. If we are constantly concerned about whether our actions will be the subject of complaint, and that such complaint is likely to lead to legal action or disciplinary proceedings, a relationship of suspicious formality between persons is inevitable.

- Culpability may attach to the consequence of an error in circumstances where substandard antecedent conduct has been deliberate, and has contributed to the generation of the error or to its outcome. In case of errors, the only failure is a failure defined in terms of the normative standard of what should have been done. There is a tendency to confuse the reasonable person with the error-free person. While nobody can avoid errors on the basis of simply choosing not to make them, people can choose not to commit violations. A violation is culpable.

- A correct balance of the interests of the plaintiff and the interests of the defendant should ensure that tort liability is restricted to those cases where there is a real failure to behave as a reasonably competent practitioner would have behaved. An inappropriate rising of the standard of care threatens this balance. While expectations from the professionals must be realistic and the

expected standards attainable, this implies recognition of the nature of ordinary human error and human limitations in the performance of complex tasks.

- Conviction for any substantial criminal offence requires that the accused person should have acted with a morally blameworthy state of mind. Recklessness and deliberate wrongdoing are morally blameworthy, but any conduct falling short of that should not be the subject of criminal liability. Common-law systems have traditionally only made negligence the subject of criminal sanction when the level of negligence has been high a standard traditionally described as gross negligence. In fact, negligence at that level is likely to be indistinguishable from recklessness.

- Blame is a powerful weapon. It's inappropriate use distorts tolerant and constructive relations between people. Distinguishing between (a) accidents which are life’s misfortune for which nobody is morally responsible, (b) wrongs amounting to culpable conduct and constituting grounds for compensation, and (c) wrongs calling for punishment on account of being gross or of a very high degree requires and calls for careful, morally sensitive and scientifically informed analysis; else there would be injustice to the larger interest of the society. This may not be understood as holding that doctors can never be prosecuted for an offence of which rashness or negligence is an essential ingredient. There is a need for care and caution in the interest of society; for, the service which the medical profession renders to human beings is probably the noblest of all, and hence there is a need for protecting doctors from frivolous or unjust prosecutions. Such malicious proceedings have to be guarded against and genuine complaints must be ensued with extreme punitive stings. Thus, a complainant has to produce prima facie evidence before the Court to support the charge of rashness or negligence on the part of the accused doctor.¹⁷⁶

### 2.9 Interrelationship and Implications for the concept of medical negligence

When one links the international scenario with the concept of Medical Negligence has been defined in Indian Legal System under various laws, Tort law, Criminal law, Consumer Protection Law, the following points emerge: .

¹⁷⁶Supra note
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. 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 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. When it comes to the failure of taking precautions what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence.

A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices.

The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of mens rea must be shown to exist. For an act to amount to criminal negligence, the
degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.

- The word 'gross' has not been used in Section 304A of IPC, yet it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be 'gross'. The expression 'rash or negligent act' as occurring in Section 304A of the IPC has to be read as qualified by the word 'grossly'.

- To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

- *Res ipsa loquitur* is only a rule of evidence and operates in the domain of civil law especially in cases of torts and helps in determining the onus of proof in actions relating to negligence. It cannot be pressed in service for determining per se the liability for negligence within the domain of criminal law. *Res ipsa loquitur* has, if at all, a limited application in trial on a charge of criminal negligence.\(^{177}\)

In the next chapter, the concept of Consumer Rights in relation to Medical services is discussed. It explains the historical background, development of the concept of consumer rights in India with its international perspective, and explores the relationship of the concept with ‘Patient as Consumer’ and ‘Medical Profession as Service Provider’.

\(^{177}\) Smreeti Prakash, A comparative Analysis of Various Indian Legal Systems regarding Medical Negligence, Criminal, Consumer Protection and Tort Laws; Legalserviceindia.com, Last accessed 10\(^{th}\) July 2012.