Chapter 6

CRITICAL EVALUATION

Of

The changing trends

In the law of

Medical negligence
6.1 Changing Trends visible in the case law analysis and interpretation
In the previous parts of the study, the researcher has identified, 5 indicators of changing trends in the Law of Medical Negligence, as follows

TRENDS WISE CASE LAW ANALYSIS

A) PRINCIPLES

Comments: on Trends in National Commission Judgments
The traditional basis for deciding the Medical Negligence cases is the Bolam Principle. In the selected study of 300 National Commission cases, the principle is being mentioned in increasing number. Before 1990 it is not mentioned at all, while during 1991 to 2000, in 2.12 % cases (out of 47 cases) it was mentioned in the judgment, during 2001 to 2010 it was mentioned in 16.37 % of Cases (out of 116 cases) and after 2011 till today it is mentioned in 19.85 % of the cases (out of 136 cases).

Sympathetic discussion about patient’s complaints done and patients are protected under the Consumer Protection Principle, in 1991 to 2000, is 12 %, while in 2001 to 2010 it was 32.75 % and from 2011 the principle is being used in 19.85 % of Cases.

Case laws are being referred in increasing number of cases, in one case before 1990 case laws were referred, while in 21.27 % of cases in 1991 to 2000, 57.75 % cases in 2001 to 2010 and after 2011 it is in 44.11 % of decided cases case laws are referred.

The contributory negligence of the patients is actively mentioned and sought as 10.63 % of cases in 1990 to 2000, 11.2 % of cases in 2001 to 2010 and now after 2011 it is 20.58 %, indicating increase in the awareness regarding the contributory Negligence.

The Bolitho Principle is not at all mentioned before 2000, while it is just mentioned sparingly, 4.31 % in 2001 to 2010 cases and after that 5.88 %. It indicates that the principle is now known to be mentioned more frequently though not applied up till now.
As such the National Commission has precarious role in developing new rules. In 2001 to 2010 8.62% of cases and after 2011 (136 cases) it is 7.35%)

Comments: on Trends in Supreme Court Judgments

In the Supreme Court cases, in 25% cases of 1991-2000, the Bolam Principle is mentioned in the Judgments while in 42.8% of 2001 to 2010 cases, it is mentioned. Presently since 2011 till today in all cases this important principle is mentioned.

Sympathetic discussion about patient’s complaints done and patients are protected under the Consumer Protection Principle, during 1980 to 1991 it is used in 66.66% of cases, in 1991 to 2000 is 87.5%, while in 2001 to 2010 it was 50% and from 2011 the principle is being used in 100% of Cases.

Case laws are being referred in increasing number of cases, in 33.33% of case before 1990 case laws were referred, while in 87.75% of cases in 1991 to 2000, 75% cases in 2001 to 2010 and after 2011 it is in 100% of decided cases, case laws are referred.

The contributory negligence of the patients is actively mentioned and sought only after 2000, as 0% of cases in 1990 to 2000, 35.71% of cases in 2001 to 2010 and now after 2011 it is 100%, indicating increase in the awareness regarding the contributory Negligence.

The Bolitho Principle is not at all mentioned before 2000, while it is just mentioned sparingly, 3.57% in 2001 to 2010 cases and after that in no case it is mentioned. It indicates that the principle is now known to be mentioned more frequently though not applied up till now.

The Supreme Court has major role in developing new rules. Between 1981 to 1990 in 66.66% of cases, in 100% of cases in 1990 to 2000, and in 2001 to 2010 it was 57.14% and after 2011 no case has developed new rules. Thus after the application of the Consumer Protection Act to the Medical Field, the very next decade there was
an intense legal Judicial Activism that spelt various legal principles settled as law today.

**B) DEFICIENCY**

Comments: on **Trends in National Commission Judgments**
In the present study, during 1991 to 2000, in 25.53 % cases deficiency in services was proved, in 25.53 % of cases Medical Negligence was proved and in 57.44 % cases Informed Consent was not taken. During 2001 to 2010, in 31.89 % of cases Deficiency in service was proved at the same time Medical Negligence was proved, while in 65.51 % of the cases Informed Consent was not taken. After 2011, in 44.85 % of cases deficiency was proved as well as Medical Negligence. In 75 % of the patients Informed Consent was not taken.
Thus over the years, there has been an increase in % of deficiency in service and Medical Negligence. Incidentally, there has been an increase in the % of incidences where Informed Consent is not being taken.

Comments: on **Trends in Supreme Court Judgments**
In the present study of 40 cases, during 1981 to 1990, in 66.66 % of cases deficiency in service and Medical Negligence was proved. In 33.33 % cases Informed Consent was not taken.
During 1991 to 2000, in 87.5 % cases deficiency in service and Medical Negligence was proved. In 37.5 % cases the Informed Consent was not taken.
During 2001 to 2010, in 50 % cases deficiency in service and Medical Negligence was proved. In 32.14 % cases Informed Consent was not taken. While after 2011, in all cases deficiency and Medical Negligence was proved. But also in none of the cases Informed Consent was taken.

**C) METHODS OF JUDGING**

**Type of Judgment: Structured / Unstructured**

Comments: on **Trends in National Commission Judgments**
During last 3 decades, there is an increase in structured as well as unstructured judgments, while in 1981 to 1990, only one case that has structured judgment.

Comments: on **Trends in Supreme Court Judgments**
In Supreme Court, % of structured Judgment has increased over last 4 decades, serially 66.66 %, 87.5 %, 87.71% and 100 % as the graph suggests.
Judicial Behaviour: Editorship/ Authorship

Comments: on Trends in National Commission Judgments

Only one case was included in this study from the 1981 to 1990 decade. The judgment delivered was by Judicial Behaviour that can be classified as Editorship. Next 2 decades, it was 34.04 % and 43.96 % Editorship was used, while after 2011 in 30.14 % cases the editorship was used. The editorship is supposed to be the best as the judgment depends on various references. The Authorship was used as principle in about 50 to70 % of cases in last 4 decades.

Comments: on Trends in Supreme Court Judgments

Over the last 4 decades, in Supreme Court, there has been an increase in Editorship as Judicial Behaviour, while Authorship has gradually reduced.

Court’s Analysis of Each Issue: Full/ Mixed/ Minimal /Low

Comments: on Trends in National Commission Judgments

Over last 4 decades, when the judgments of National Commission cases are analyzed, it is found that there is reduction in % of complete analysis of the cases, i.e. issues under consideration. 17.02 % in 1991-2000, 15.51 % in 2001 to 2010 and from 2011 it is 6.61 %. In 3rd decade, 2001 to 2010, about 44.68 % judgments are seen with low analysis of issues under consideration.

Comments: on Trends in Supreme Court Judgments

At Supreme Court, for the analysis of each issue under consideration, % of full or complete analysis has been increasing as depicted in graph. So thus it can be said that the apex court is through with its approach toward Medical Negligence.

Judicial Response to Each Issue: Strongly Responsive / Weakly Responsive / No Responsive

Comments: on Trends in National Commission Judgments

When analyzed, the Judicial Response has been divided in to Strongly Responsive, Weakly Responsive and non Responsive. For the National Commission Judgments, the Judicial Response to each issue has been variable. Last 3 decades, rather it is found that the non responsive nature of Judge’s is increasing.

Comments: on Trends in Supreme Court Judgments
The Supreme Court has been traditionally strongly responsive for the issues under consideration. The graph above shows the trend.

**Judge’s Unawareness of Fallacies in the System and Medical Field**

Comments: on *Trends in National Commission Judgments*
At the National Commission, there is an increased trend of accepting or formally quoting by the judges that, they are unaware of the fallacies of the Medical Field.

Comments: on *Trends in Supreme Court Judgments*

At Supreme Court, only in the decade of 2001-2010, in 7.14 % of the cases, the Judges have formally mentioned that they are unaware of the fallacies of the medical field. Otherwise in all the past 2 decades they have formally not mentioned the unawareness.

**D) EVIDENCE**

Comments: on *Trends in National Commission Judgments*
Regarding use and acceptance of the expert witness, expert evidence and Medical Literature; there is variability between 25 to 66 % in all the 4 decades. It is true that there is an increase in the use and acceptance of the same.

Comments: on *Trends in Supreme Court Judgments*

In Supreme Court, the trend to use and acceptance of expert witness, expert evidence and Medical Literature is increasing and last decade it was around 87.5 %, while after 2011, the use and acceptance is 100 %. So it is a positive sign of respecting the Expert Witness and Evidence.

**E) COMPENSATION**

Comments: on *Trends in National Commission Judgments*

In National Commission Judgments, the trend of awarding compensation is as follows

In 1991-2001 - 25.53 %;

2001 to 20110 - 31.39 %
and after 2011- 44.85 %

Comments: on **Trends in Supreme Court Judgments**
At Supreme Court, the trend of awarding compensation is much higher
1981 to 1990 – 66.66 %;
1991 to 2001- 75 %;
2001 to 2010 – 53.57 % and
100 % for the cases after 2011.

Thus trend of awarding the compensation is higher at Supreme Court than at National Commission.

**Method of Compensation Calculation:**¹
In most cases the remedy for a victim of medical negligence through a Consumer Court would be to get compensated. But how is this compensation fixed? You cannot fix a value to your dear ones in terms of money. Can you? The Consumer Court has formulated a method to calculate, a not so accurate but fair, compensation amount. Let us read more on this below.
There are a lot of factors including pecuniary factors like loss of future earnings (if the victim is dead or disabled), medical expenses incurred, future medical expenses (if the victim still requires medical assistance), cost of litigation etc. and non-pecuniary factors like compensation for the pain and suffering, non-enjoyment of life, shortening of life expectancy etc.

Calculating the loss of future earnings is a complex process. The Supreme Court in *Sarla Verma & Ors. Vs. Delhi Transport Corp.& Anr*² has laid down the three step process through which this can be calculated. The first step would be to calculate the ‘multiplicand’ (a number that is to be multiplied with another – in 2 * 5, 5 is the multiplicand). In this step the annual income of the deceased or the injured is

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² (2009) 6 SCC 121
calculated. The deceased/injured would have spent on himself is deducted. The balance is the Multiplicand.

Step 2 is to determine the Multiplier. In this step an estimate is made on the years of active career of the person. From this, some years are deducted under heads like imponderables in life, uncertain economic factors etc. The resulting number is the multiplier. For example if x, dies at the age of 35, and if his expected period of active service is estimated to be till 60 years, then the multiplier would be 25. From this, let’s say, 7 years are deducted under imponderables in life and economic factors, then the final multiplier will become 18.

The third step is to multiply the Multiplicand with the multiplier, which will give the compensation amount under Loss of future earnings. The pecuniary factors can be, to an extent, accurate but the non pecuniary factors cannot be accurate. You cannot measure the mental sufferings and give a value to it. The courts usually fix an amount which it deems will compensate the non pecuniary damages.

These factors vary depending on the nature of the cases. For example in the case where a person has fully recovered from the damages caused due to the medical negligence, he may not be given compensation for loss of future earnings. Similarly if the medical expense of the victim is covered by a third party, for example, if it is covered by the company he works in, then he might not get compensation for medical expenses.

In most medical negligence cases the consumer court has awarded compensation less than the amount asked for by the complainant. One can argue that since it is the complainant who has suffered all the physical and mental damages, he is the best person to determine the compensation he needed. But there are times people ask for unreasonable amounts or may think that a particular amount is reasonable, when it is actually not. You will always over value yourself or your loved ones. So better leave it to the courts to decide and hope that you’ll get a fair compensation. Or maybe, not go for a case and fall in love with the doctor.\(^3\)

\(^3\) Id
**Anuradha Saha Case:** Example: On October 21, 2011, NCDRC awarded a total of Rs. 1.7 Crores compensation against the Kolkata doctors and AMRI Hospital but deducted more than Rs. 40 Lakh on ground of alleged “interference” by Dr. Saha (although Apex Court held only the Kolkata doctors/hospital guilty for Anuradha’s death) and also due to the death of one of the guilty doctors, Dr. Roychowdhury. Although this was the highest compensation ever awarded in India for death of a patient due to “medical negligence”, Dr. Saha has challenged the said order passed by NCDRC on numerous grounds including the fact that the NCDRC did not follow settled principles for calculating compensation in “medical negligence” cases while dismissing more than 98% of Dr. Saha’s claim. The NCDRC also used the “Multiplier” method for calculation of compensation which has never been used any case of “medical negligence” until now. In fact, “Multiplier” method is used under Section 163A of the Motor Vehicle Accident Act for awarding compensation to auto accident victims in “no fault” accident. Obviously, the “Multiplier” method minimizes the compensation to be paid by the rash and negligent doctors and hospitals.\(^4\)

### 6.3 Changing Trends in the selected case studies from Pune district

The 10 cases from Pune were studied and analyzed by applying same variables, as that for the case law analysis. This is compared and contrast between National and Local trends.

1. **Type of Case**
   
   The analysis of 10 Pune Cases from Pune that included 7 decided cases at Pune District Consumer Redressal forum and 3 cases from Pune directly approached State Consumer Commission.

   In 4 cases Medical Negligence was proved out of 7 cases at District Forum while in 6 cases it was not proved, that includes 3 cases at district forum and 3 cases at State commission.

2. **Patient Place**

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\(^4\) Anonymous, Anuradha Saha Death Case Ends In Supreme Court: Judgment Reserved In Highest “Medical Negligence” Case In Indian Medico-legal History (April 11, 2013) 
All the 10 cases are from urban origin where the patients are from urban area, while no case is from rural area

3. **Patient Status**
Out of 10 cases, in 1 case patient died while in rest 9 cases patients were disabled. In the case where patient died, Medical Negligence was proved at district level, while from disabled cases, only 3 cases Medical Negligence was proved and in others not yet proved

4. **Patient Education**
All the 10 cases, the petitioners were Educated, so as such no relation between Medical Negligence and the education of the petitioner was found.

5. **Type of Doctors**
In the sample of 10 cases, all the 10 doctors were found to be specialists and there was no General Practitioner. And 4 of the specialists was found negligent by the district forum.

6. **Inclusion of Hospitals**
In 2 cases out of 10 cases, the hospitals were included and were respondents along with the doctors. In both the cases where hospitals were also made party, Medical Negligence due to deficiency in service was proved, while out of remaining 8 cases where hospitals were not included, in 2 cases the Medical Negligence was proved and rest 6 cases it was not proved.

7. **Appeal Filed By**
Out of 10 cases, the appeals in State Commission were filed by, 7 appeals by patients, 2 appeals by doctors and one appeal by a hospital.

8. **Number of Complainants:**
Out of 10, in nine cases, one complainant and in one case many complainants filed cases against doctors.

9. **Number of Respondents:**
Out of 10 cases, in 4 cases single respondent and in remaining 6 cases many respondents were there. In each of the category, in 2 cases each Medical Negligence was proved.

10. **Complainant’s Version:**
Out of 10 cases in 3 cases, the complainant’s version was accepted and in 7 cases it was not accepted. In all the 3 cases where, complainants i.e. patient’s version was accepted, Medical Negligence was proved, while in only one case where, though
complainant’s version was not accepted, Medical Negligence was proved and in remaining 6 cases it was not proved.

11. **Respondent’s Version:**
In 7 cases, respondent’s version was accepted and in 3 cases it was not accepted. So out of 7 cases, in one case in spite of accepting respondent’s version, Medical Negligence was proved and in 3 cases in which respondent’s version were not accepted, the Medical Negligence was proved.

12. **Expert Witness/Evidence:**
In 4 cases the expert witness/evidence was accepted by the Judges and in 6 cases not. In all the four cases Medical Negligence was proved.

13. **Expert witness:**
In 6 cases Expert witness was considered, out of which 4 cases Medical Negligence was proved and in remaining 2 cases as well as 4 cases in which expert witness was not accepted, Medical Negligence was not proved.

14. **Expert Evidence:**
Out of 4 cases in which Expert evidence was accepted, Medical Negligence was proved in 2 cases, and in remaining 6 cases in which Expert Evidence was not accepted in 2 cases Medical Negligence was proved.

15. **Case Laws Referred:**
Out of 4 cases in which case laws were referred, 2 cases were Medical Negligence proved and out of 6 cases in which case laws were not referred, in 2 cases Medical Negligence was proved.

16. **Medical Literature Referred:**
In 3 cases Medical Literature was referred out of 10 cases, while out of that only one was found to be negligent. While out of 7 cases where Medical Literature was not referred, in 3 cases Medical Negligence was proved.

17. **Contributory Negligence by the patient:**
In all the 10 cases, contributory Negligence was not proved, out which in 4 cases Medical Negligence was proved.
18. **Bolam Principle Mentioned:**
In all the 10 cases, the Bolam Principle was not mentioned by the Judges in the Judgments, and in 4 cases Medical Negligence was proved, in remaining 6 it was not

19. **Compensation awarded & consumer protection principle.**
In 4 cases Medical Negligence was proved and compensation was awarded, thus the Consumer Protection Principle was confirmed in the Judgments.

20. **New Rule in the Judgment & Bolitho Principle Used**
In all the 10 cases, no new rule was postulated by the Court, as well as the Bolitho Principle was not mentioned

21. **Informed consent taken**
In 3 cases Informed Consent was taken, out of which in one case Medical Negligence was proved. In remaining 7 cases the Informed Consent was not taken, out of which in 3 cases the Medical Negligence was proved.

22. **Type of judgment**
In 4 cases the Judgment was structured out of which in 2 cases Medical Negligence was proved and in remaining 6 cases where the judgments were unstructured, in 2 cases Medical Negligence was proved

23. **Judicial Behaviour**
In 4 cases the Judicial Behaviour was Editorship, meaning referred case laws, medical literature, witnesses and evidences, out of which in 2 cases Medical Negligence was proved. In remaining 6 cases the Judicial Behaviour was Authorship, meaning decision was given without referring the witness, Evidences, case laws or Medical Literature. Out of that 2 cases were found to be Negligent.

24. **Specialty**
The specialties involved in the cases under study at local level at Pune.
Out of 3 Neuro Surgery cases in 2, Medical Negligence was proved. In one cardiology case, Medical Negligence was proved Out of 2 Gynaecology cases, in one Medical Negligence was proved.

An overview of changing trends in a comprehensive manner is presented in the table as below:
### Table No. 137
Overview of Changing Trends in the law of Medical Negligence

<table>
<thead>
<tr>
<th>Factors</th>
<th>Pre CPA Trends</th>
<th>Post CPA Trends</th>
<th>Current Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predominant legal principle</td>
<td>Tort law and Criminal Law</td>
<td>Tort law as aligned with the concept of deficiency and compensation</td>
<td>Delay due to multiple appeals, so new approach does not make much impact</td>
</tr>
<tr>
<td>Position of Medical professional</td>
<td>S/He was held with trust, high regard, infallible</td>
<td>S/He is doubted, shopping attitude, Commercialized relationship</td>
<td>Malpractice insurance increases cost in turn on patient</td>
</tr>
<tr>
<td>Pre eminence of expert opinion (Bolam Principle)</td>
<td>Yes</td>
<td>Partially present</td>
<td>Slowly changing, Discretion lies with the judge</td>
</tr>
<tr>
<td>Method of Judging</td>
<td>Editorship</td>
<td>Mixed between editorship and authorship</td>
<td>More towards authorship due to Bolitho principle</td>
</tr>
<tr>
<td>Deficiency</td>
<td>Not included in Negligence</td>
<td>Used interchangeably with negligence</td>
<td>Concept of informed consent is enforced with CPA</td>
</tr>
<tr>
<td>Logical Relevance of Expert opinion ( Bolitho principle)</td>
<td>Not considered</td>
<td>Considered but not significant</td>
<td>The relevance is increasing with new cases</td>
</tr>
<tr>
<td>Position of Patient</td>
<td>Patient's rights limited to contractual and benevolent relationship</td>
<td>Multiple rights to patients predominantly as consumer. Penal liability is</td>
<td>Speed of remedy is slow, so no patient safe approach. So patients rights are unaddressed.</td>
</tr>
</tbody>
</table>
between doctor and patient. Penal liability in serious cases insignificant. Remedy is cheaper.

<table>
<thead>
<tr>
<th><strong>Time Taken for judgment</strong></th>
<th>Lengthy</th>
<th>Lengthy due to many appeals and pendency</th>
<th>Lengthy due to many factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approach to Compensation</strong></td>
<td>Tort law approach based on extent of damage</td>
<td>Multiplier Method is applied</td>
<td>Patients demanding punitive approach like of US</td>
</tr>
<tr>
<td><strong>Perception</strong></td>
<td>Favourable to doctors, not sensitive to patient and only small number of patients approached court. 40 case at Supreme Court in 5 decade</td>
<td>High degree of proving negligence among medical professionals 36 % at National Commission 300 cases in 2 decades</td>
<td>Increase in cost of medical services and absence of uniform standards in medical profession. Comprehensive better mechanism is needed. Proper balancing of the professional integrity and patient safety is required.</td>
</tr>
</tbody>
</table>
6.5 Changing Trends in Professional approach

The image of medical professionals in India has veered from saint like saviours of life to demons by criticizing doctors for medical negligence and malpractice. Negligence claims clearly do have the potential to threaten the medical profession in a number of ways. They can expose doctors to external scrutiny by colleagues, media, the judiciary etc. harming their career prospects. It is very difficult for an Indian physician to accept that a negligence suit is now a professional hazard. At the onset of the suit the medical practitioner experiences intense anger because of the shock he experiences due to the break of the trust built up between him and the patient. He feels betrayed by his patient and the accusation of professional incompetence challenges the interior core of his professional integrity, resulting in anger and frustration. A medical negligence suit challenges the reputation, ego, self-esteem, and confidence of a physician. Mood swings, depression, and anxiety affect physicians, in turn affecting their personal and professional life.\(^5\)

However, the Consumer Protection Act of 1986, which provides easy access to justice, has brought a legal revolution to India as a result of its cost-effective mechanisms and popular support. At the same time, these mechanisms pose a great legal challenge to the traditional courts which conduct litigation in orthodox ways. In this age of consumers, the regime of Indian consumer law will undoubtedly rule Indian markets and bestow a new phase on the existing Indian legal structure with its strong ancient legal foundations.\(^6\)

**Trends in Judicial Outcomes and Consequences for Health Care\(^7\)**

The last two decades have seen a phenomenal rise (compared to the earlier decades) in litigation concerning the health of individuals of communities and society at large. An obvious off shoot of these developments has been litigation concerning


\(^7\) Mihir Desai & Kamayani Bali Mahabal, Healthcare Case Law in India, Report(2007);CEHAT Mumbai, pp.163
health care. However, before we see the recent trends it becomes crucial to look at the trends concerning health care in the first three decades after independence. Till the early 1980s, the judicial response to health related issues in India was essentially centred around cases of medical negligence or entitlements of employees under the Workmen’s Compensation and ESI Acts. Apart from this, there were a few cases concerning drugs and other related issues. Under the welfares policies of the government many labour laws were enacted. Some of them dealt with health and health care. In the last 50 years, a majority of the decisions under these laws have been concerned with a very limited range of issues. Employees who suffer injury at the workplace are entitled to compensation. A large number of cases are around disputes about whether a disease or injury was acquired during the course of employment or not. The second type of controversy has been around whether a particular employer or employee falls within the mandate of the Acts under which protection is sought. The third major area of dispute has been the quantum of compensation to which an employee would be entitled. In recent times the courts have played a more proactive role and have laid down strict conditions of health and safety for the workmen like it was done by the Supreme Court in the case of asbestos manufacturing industry.

But it must be borne in mind that there are a relatively smaller numbers of employees governed by health care legislation in the private sector. Besides, in recent times the attitude of the courts towards these employees has not been very positive. For instance, recently the Supreme Court held that a casual workman is not covered under the Workman’s Compensation Act.

The second branches of litigation concerning employees are cases regarding government servants. A large number of these cases pertaining to the rights of government employees to reimbursement of medical expenses incurred in private health care sector. At around this time patients started approaching the courts in matters concerning medical negligence. They were required to file suits in the district courts, which were highly time consuming, expensive and in many cases resulted in failure. The law followed in these matters was the English common law (judge made law) concerning torts and more particularly negligence. Though the legal tools to fight against medical negligence have always been available, the procedural tools
were highly inadequate. So the cases were few. This situation changed dramatically from the mid 1980s with the passage of the Consumer Protection Act and a consequent decision of the Supreme Court that medical services (except those providing totally free medical services) were covered under the Act.  

On matters of negligence the development of litigation has been quite phenomenal. Of course, the legal principles on this issue remain the same as they were more than 50 years ago. It is necessary to show duty to take care; it is important Healthcare Case Law in India 163 Adv. Mihir Desai to point out the standard of care required; and, it is crucial to establish the linkage between negligence and injury. Even so, the courts have started utilizing some recently derived principles such as informed consent. On the other hand, the Supreme Court in recent times has whittled down criminal responsibility of doctors by holding that doctors could not be held criminally liable unless they are guilty of ‘gross’ negligence. Besides, police complaints cannot be filed without another doctor’s opinion concerning negligence. Such opinions are very difficult to obtain. Although victims of medical negligence have the option of also approaching medical councils, their experience, with these Councils has, by and large, been negative. The general feeling is that medical councils are overprotective of doctors.

Drugs and Cosmetics Laws have been existence since before independence. Judicial decisions under these laws have been mainly in respect of licensing conditions and classification of various items as drugs. The courts have not often interfered with the strict licensing conditions concerning drug manufacture, storage and distribution. They have also given a broad definition to the term ‘drug’ preventing escape route for manufacturers from strict quality control. The next decade, will of course witness gruelling battles on drug patents. With product patents being now available coupled with strategic ever greening of patents by large pharma industries there are likely to be pitched legal battles between patient rights groups, state and the industry.

In recent years there has also been a large amount of litigation concerning the right to practice medicines by people holding qualifications not recognized under the law.

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8 Id; pp.163
9 Id; pp.163
10 Mihir Desai &Kamayani Bali Mahabal, Supra note 6
Since the 1980s with the rapid privatization of medical education many unaffiliated, unrecognized colleges have cropped up offering diplomas and degrees in branches of medicines not recognized under the law. Instances of these are electropathy and electro homeopathy. Gullible students take these courses paying high fees only to realize later that these qualifications have not been duly recognized by any authority. The courts have consistently refused to interfere in these matters and have disallowed such persons from practising medicine. However, the courts have acknowledged the power of State governments to recognize certain qualifications on their own merits. Courts have also come down heavily against cross practice in medicine.  

The 1990s saw litigation in two new branches of health care law. First has been in respect of the law concerning HIV/AIDS. Though as yet there has been no central law relating to this, the courts have intervened in matters concerning the rights of HIV positive persons especially in employment related laws and through the use of the right to life to include the right to live with human dignity. The development in this area of law has been very interesting. In the 1980s when there was little awareness about this issue, the courts were inclined to focus on protecting society from HIV positive persons. But in the 1990s with a growing understanding of the issue the courts have stepped in to protect the confidentiality of positive persons, prevent discrimination in employment and other aspects of life. In the next few years, we are likely to witness a proliferation of litigation concerning this branch of law, especially if the new law in the making rolls out.

Similarly, after the enactment of the Organ Transplantation Act in the 1990s some amount of litigation emerged on the issue. The litigation till now has been around the issue of who can donate organs. But as cadaver transplantation becomes more popular, a plethora of issues under this law are likely to arise. Euthanasia is not recognized in India. However, debates have started on this issue and one can foresee some litigation on this controversial issue. Another area where perspectives have changed over a period concerns mental health. From treating mentally ill patients as those who deserve to be locked up and forgotten the perspective now is

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11 Mihir Desai & Kamayani Bali Mahabal, Supra note
12 Id, pp.163
much more sensitive and favourable to them. This is also reflected in the Disabilities Act passed in the 1990s. Earlier the law as well as litigation concerned rights vis a vis the mentally ill. Now it is increasingly tending to be a perspective of the rights of disabled persons. Even so, the main area of litigation in this branch has been around conditions of homes for the mentally ill and their confinement in prisons. However, with the passage of time and more awareness of the complexities of the problem courts are likely to be more frequently approached.  

Women’s health as a separate subject was always recognized through various provisions in the Factories Act, laws concerning abortion and the Maternity Benefit Act. But the special importance of women’s reproductive rights emerged in the 1980s after struggles of women’s groups on the use of women as guinea pigs for testing contraceptives. The courts have been called upon to restrain such experiments. The courts have been approached for failure of sterilization operations but in these matters they have, by and large, refrained from interfering.

In the only case relating the Right to Food currently pending in the Supreme Court, (P. U. C. L. vs. State of W. B. & Ors.) the Court has been satisfied with giving certain directions so as to see that people do not die for the want of food. The Right to Food includes the Right to Health and Health-care and it is not merely the right to receive food in terms of minimum calories, but, it includes the Right to Adequate Food. The adequacy will then be measured by not only what is necessary for survival, but by a person’s health or by his ability to pursue a normal active existence. The concept of adequate food for the maintenance of health, not only requires a minimum calorific intake but also a certain balance of nutrients. The Right to Food should be understood together with a range of other rights – access to health care, medical facilities, drinking water and sanitary facilities. Unfortunately, the Supreme Court has not yet laid down the inter-relationship between Right to Food and Right to Health.

Public Interest Litigation, Fundamental Right and its Consequences.

Two developments in the 1980s led to a marked increase in health related litigation. First was the establishment of consumer courts making the suing of doctors and

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13 Id.; pp.163  
14 Id.; pp.163
hospitals for medical negligence and deficiency in service easier and cheaper. Second was the growth of public interest litigation, an expanded interpretation of the Right to Life as a fundamental right and one of its off shoots being the recognition of health and health care as a fundamental right. The public interest litigation movement in India began in late 1970s. Its foundation is the enforcement of fundamental rights guaranteed under the Constitution of India. Any citizen could trigger off the judicial mechanism by claiming a violation of Fundamental Rights, either of himself or of other individuals or of the citizenry at large. Fundamental Rights existed even before the late 1970s. The real push for the PIL movement came from an expanded interpretation of the Fundamental Right to Life which is enshrined in Article 21 of the Constitution. This reads:

No person shall be deprived of his life or personal liberty except through procedure established by law.

Till the 1970s, by and large, the courts had interpreted ‘life’ literally i.e. right to exist. The late 1970s onwards an expanded meaning started to be given to the word ‘life’. Over the years it has come to be accepted that life does not only mean merely animal existence but the life of a dignified human being with all its concomitant attributes. This has been interpreted to include a healthy environment and effective health care facilities. As we have seen in earlier Chapters to begin with, the right to health as a fundamental right grew as an off shoot of environmental litigation. Pollution free environment as a fundamental right presupposes the 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. To begin with, the right to decent environment was recognised and from that followed the right to public health, health and health care. Even while dealing directly with the right to health, the first issues concerned employees’ health within a work place.  

It was only in 1991, in C.E.S.C. Ltd. vs. Subhash Chandra that the Supreme Court placed reliance on international instruments and declared that the right to health was

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15 Mihir Desai &Kamayani Bali Mahabal, Supra note 6
16 AIR 1992 SC 573
a fundamental right. The question however remains whether a particular right is a
positive or a negative right. A negative right is one which does not require the State
to take any positive steps for its realization but only needs the State to ensure that
no actions are taken that deprive the person of the right. For instance, a negative
right to health would mean that the state should ensure that there is no pollution or
that the drugs supplied by companies are of good quality. On the other hand, a
positive right would mean that the State should build hospitals, ensure provision of
drugs at cheap rates, etc. While the Supreme Court has on occasion implicitly held
that the right to health was a positive right, on most occasions its treatment has been
as a negative right.

In Vincent Panikurlangara vs. Union of India\textsuperscript{17}, the Supreme Court observed “In a
welfare State, therefore, it is the obligation of the State to ensure the creation and
the sustaining of conditions congenial to good health.” Because of having recognized
that right to health and health care as a fundamental right what follows?
Fundamental rights are generally available only against the state. They prescribe the
obligations of the State. In a poverty ridden country like India, does it mean that the
State must provide free medical health care facilities to all? In a situation where there
is increasing privatization of the health care systems, where the proportional annual
budget for health is shrinking, where the cost of health education is growing
exponentially this seems very unlikely. No court has yet said that the State is bound
to provide free medical care to all the citizens. This would be the consequence if the
right to health care was recognized as a positive right. The other aspect would, of
course, be the quality of health care provided by the State. Infrastructure does not
just comprise primary health care centres but even in government run hospitals in
metropolitan cities service is crumbling. These institutions are plagued by a lack of
enough beds, sufficient medicines and other similar problems. The Courts including
the Supreme Court have not adequately dealt with this aspect. They have mainly
been concerned with pious declarations of health being a fundamental right and
peripheral and not so peripheral issues such as the rights of government employees
to be treated in government hospitals, emergency medical care and the like. Even in
respect of emergency health care, the private sector has not yet come within the
sweep of the Courts. In the case of Paschim Banga Khet Mazdoor Samiti vs. State of

\textsuperscript{17} AIR 1987 SC 990, (1987) 2 SCC 165
W.B.\textsuperscript{18} the Supreme Court observed that providing adequate medical facilities was an essential part of the obligation undertaken by the State in a welfare state. And failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in the violation of his right to life guaranteed under Article 21. Although the responsibility of the State and government hospitals is well provided by a radical interpretation of the Constitution, there is no definite corresponding legal duty imposed on private hospitals and practitioners to treat emergency cases. The judgments mainly focus on the duty of the State and the government hospitals. Of course, in respect of medico legal cases, the Supreme Court has held that doctors are obliged to treat medico legal patients in without insisting on prior paper work in both private and public sector.\textsuperscript{19}

The Supreme Court and the high courts have been intervening in a much more active manner in the last few years on the issue of healthcare. However, these courts are required to look into the issues of patents and drug price control alsoas the private obligations in public interest, in order to create real impact. As in the case of education, private sector should be held accountable in the area of healthcare with universal coverage for poor masses. Meanwhile public sector healthcare system also should improve since healthcare has deeper socio-political and economic significance.

The judiciary will be vexed with the task of elaborating the right to healthcare and spell out the joint and several obligations of state and private sector healthcare providers.\textsuperscript{20}

As a human right, health is a social, economic and political issue adversely affected by inequity and poverty. Current scenario has urban bias and regional imbalances. Health expenditures are declining. Thus, the existing system requires reconstruction especially due to the dearth of a comprehensive legislative framework on national health policy,.Such a comprehensive legislation should create conditions conducive to restoring balance in the health sector. It should be further sustained by making it enforceable as a fundamental ‘Right to Health Care’. Universal Access to Health

\textsuperscript{18} (1996)4 SCC 37
\textsuperscript{19} Paschim Banga Khet Mazdoor Samiti vs. State of W.B; Supra Note 17
\textsuperscript{20} Id.
Care will require further restructuring of health finance and the introduction of universal coverage of health care.\(^{21}\)

**Recent Judicial Trends in Medical Negligence\(^{22}\)**

In *A.S. Mittal v. State of UP*,\(^{23}\) an irreparable damage was done to the eyes of some of the patients who were operated at an eye camp organized by the government of Uttar Pradesh. Some of the patients who underwent surgery could never see the light of the day, i.e. whatever little vision they had even that was lost. The apex court coming heavily on the erring doctors held that, “the law recognizes the dangers which are inherent in surgical operations and that will occur on occasions despite the exercise of reasonable skill and care but a mistake by a medical practitioner which no reasonably competent and a careful practitioner would have committed is a negligent one.” The compensation was awarded. Most important contribution of this decision is that even though service rendered free of charge does not come under the purview of the Consumer Protection Act yet the court went a step ahead in recognizing that although no direct charges were paid by the patients but the State had paid on behalf of the patients to the doctors engaged in the free eye camp. But the Punjab State Commission did not give relief to the complainant who has undergone sterilization operation in the Punjab Government Hospital free of charges and became pregnant subsequently and gave birth to a child. The State Commission was of the view that the complainant was not a consumer because services offered were free of charge.\(^{24}\)

Further, in *State of Haryana v. Santra*,\(^{25}\) the court upheld the decree awarding damages for medical negligence on account of the lady having given birth to an unwanted child due to failure of sterilization operation because it was found on facts that the doctor had operated only the right fallopian tube and had left the left fallopian tube untouched.

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\(^{22}\) Rajiv Kumar Khare, LAW OF TORTS, MEDICAL NEGLIGENCE AND CONSUMER PROTECTION, 2010 pp.37

\(^{23}\) AIR 1989 SC 1570

\(^{24}\) See, Paramjit Kaur v. State of Punjab, III (1997) CPJ 394 (Punjab SCDRC)

\(^{25}\) (2000) 5 SCC 182
tube untouched. The patient was informed that the operation was successful and was assured that she would not conceive a child in future. A case of medical negligence was found and a decree for compensation in tort was held justified. However, the apex court has explained in State of Punjab v. Shiv Ram\textsuperscript{26}, that “merely because a woman having undergone a sterilization operation becoming pregnant and delivering a child thereafter, the operating surgeon or his employer cannot be held liable on account of the unwarranted pregnancy or unwanted child. Failure due to natural causes, no method of sterilization being fool proof or guaranteeing 100% success, would not provide any ground for a claim of compensation.” The court after referring to several books on Gynecology and empirical researches concluded that “authoritative text books on gynecology and empirical researches recognize the failure rate of 0.3% to 7% depending on the technique chosen out of several recognized and accepted ones.”

Facts of Achutrao Hari Bhau Khodwa v. State of Maharashtra\textsuperscript{27}, bring a different kind of negligence exhibited by the doctors. In this case it was alleged that a mop was left in the body of the patient which resulted in the formation of pus and eventually leading to her death. The court held that the doctrine of res ipsa loquitur is clearly applicable and the State is liable to pay compensation for the negligence of the doctors. Poonam Verma v. Ashwin Patel\textsuperscript{28}, reflects yet another reckless act on part of the doctor. In this case a doctor who was registered as a medical practitioner and was entitled to practice in homoeopathy was found to be guilty of negligence for prescribing allopathic medicines resulting in the death of the patient. The doctor was grossly negligent and in clear breach of duty as a doctor. He defied all sense of logic and forgot his ethics. It is submitted that it would have been better had the doctor been prosecuted under criminal negligence as he violated section 15(3) of the Medical Council Act, 1956. His conduct also amounts to actionable negligence for having failed to take due care as indicated in earlier Supreme Court decision in Dr. Laxman Joshi case\textsuperscript{29}. The claim of the appellant was decreed as against the defendant for Rs. 3,00,000/-. After more than a decade of the decision in Poonam

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{26} (2005) 7 SC 1
\item \textsuperscript{27} AIR 1996 SC 2377
\item \textsuperscript{28} AIR 1996 SC 2111
\item \textsuperscript{29} AIR 1969 SC 128
\end{itemize}
\end{footnotesize}
Verma case, another matter came before the National Commission in Prof. P. N. Thakur & Anr. vs. Hans Charitable Hosp. & Ors. Wherein allopathic treatment was given by non-medical practitioner specialized in Unani System. The patient suffered from fever and repeated bleeding from nose which resulted in rigors in patient as a result of which his condition deteriorated. A small nasal pack was placed anteriorly. The patient died due to choking of air passage. No efforts were made to clear blocked airways by the doctor as he did not appreciate properly the course of action to be followed in such case. The Opposite Party, i.e. the Hospital was held liable for allowing unqualified person treat complicated and emergency cases.

In certain cases, it is seen that the complainants have requested the relief which is not given under the Consumer Protection Act, 1986. In such cases, the courts/forums have refrained to award remedies so claimed. For example, in Parmod Grover & Ors. v. Manvinder Kaur (Dr.) & Ors., complications during pregnancy resulted in death of the patient. The complainant alleged medical negligence and claimed relief in the form of permanently restraining and debarring Opposite Parties from practicing medical profession and cancellation of their medical certificates. The relief was denied to the complainant as, according to the court, it cannot be granted under section 14 of the Consumer Protection Act, 1986. Similarly direction regarding closure of OP nursing home was also not allowed under section 14 of CPA with a direction that the complainant is at liberty to approach civil court.

Indian Medical Association v. V.P. Shantha is considered to be the landmark judgment as it has not only widened the ambit of the Consumer Protection Act by stating that the Medical practitioners are not immune from a claim for damages on the ground of negligence but also have issued several directions of immense significance for ensuring welfare of the consumers. In Kishori Lal v. E.S.I Corporation, the appellant was insured with the ESI Corporation and deductions were made from his salary by the employer and deposited with the ESI Corpn. The appellant’s wife was admitted in ESI dispensary at Sonepat for treatment of diabetes, where her condition deteriorated and who later was examined in a private medical practitioner specialized in Unani System. The patient suffered from fever and repeated bleeding from nose which resulted in rigors in patient as a result of which his condition deteriorated. A small nasal pack was placed anteriorly. The patient died due to choking of air passage. No efforts were made to clear blocked airways by the doctor as he did not appreciate properly the course of action to be followed in such case. The Opposite Party, i.e. the Hospital was held liable for allowing unqualified person treat complicated and emergency cases.

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hospital. There it was found that she was wrongly diagnosed at ESI dispensary. The appellant alleging deficiency in service filed a complaint under CPA. The Supreme Court in revision petition held that "services rendered by medical practitioners of hospitals / nursing homes run by ESI Corporation cannot be regarded as service rendered free of charge since sections 39 and 42 of the ESI Act contemplate contributions from both the employer and the employee, which can be deemed to be fee for the service. Thus wife of the complainant was considered to be the consumer under the CPA.

Some of the directions include: (i) a medical insurance policy -beneficiary of the service for which payment has been made by the insurance company - consumer. (ii) the relationship between the doctor and a patient carries with it certain degree of mutual confidence and trust and therefore the services of personal nature but no relationship of master and servant contract between them cannot be treated as a “contract of personal service” but a “contract for services.” (iii) The three categories: (a) Where services are free of charge to everybody - Doctors and hospitals are outside the purview of “service” under Act; (b) Where charges are required to be paid by everybody- Doctors and hospitals would clearly fall within the ambit of “service”. (c) Where charges are required to be paid by persons availing the services but certain categories of persons who cannot afford to pay are rendered service free of charge. Doctors and hospitals would fall within the ambit of the expression “service”; persons who are rendered free service are the “beneficiaries” and as such come within the definition of “Consumer”. (iv) In complaints involving complicated issues requiring recording of evidence of experts, the complainant can be asked to approach the Civil Court for appropriate relief as provided under Section 3 of the Act. (v) Where the deficiency in service is due to the obvious faults such as removal of the wrong limb or the performance of the operation on a wrong patient or giving injection of a drug to which the patient is allergic without looking into the outpatient card containing the warning or use of wrong gas during the course of an anesthetic or leaving inside the patient swabs or other items of operating equipment after the surgery, such cases can be disposed of by the consumer courts.35

35 Id. 21
In one of the most recent decision in *Kusum Sharma v. Batra Hospital*[^36], the Hon”ble Supreme Court has settled the law relating medical negligence. Mr. Dalveer Bandari, J., scrutinizing the cases of medical negligence both in India and abroad specially that of the United Kingdom has laid down certain basic principles to be kept in view while deciding the cases of medical negligence. According to the court, “while deciding whether the medical professional is guilty of medical negligence *the following well-known principles must be kept in view:*[^37]

- Negligence is the breach of a duty exercised 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 is an essential ingredient of the offence. The negligence to be established by prosecution must be culpable or gross and not the negligence based upon the error of judgment.
- The medical professional is expected to bring a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither 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.
- A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.
- In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of the other professional doctor.
- The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

[^36]: (2010) 3 SCC 480
[^37]: Id. Para 89
Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. 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 would not be conducive to the efficiency of the medical profession if no doctor could administer medicine without a halter round his neck.

It is our bounden duty and obligation of the civil society to ensure that medical professionals are not unnecessarily harassed or humiliated so that they can perform their professional duties without fear and apprehension.

The medical practitioners at times have to be saved from such a class of complainants which use criminal process as a tool for pressurizing the medical professionals/hospitals, particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals.

The court did not rest the case here, i.e. by laying down eleven principles for determining the breach of duty by medical professionals/hospitals, but went a step ahead by observing that, “In our considered view, the aforementioned principles must be kept in view while deciding the cases of medical negligence.” The court further adds a word of caution by stating that, “We should not be understood to have held that doctors can never be prosecuted for medical negligence. As long as the doctors have performed their duties and exercised an ordinary degree of professional skill and competence, they cannot be held guilty of medical negligence. It is imperative that the doctors must be able to perform their professional duty with free mind.”

Article 141 reads: “Law declared by the Supreme Court shall be binding on all courts within the territory of India”.

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38 Supra note94, para 90
The above listing of “basic principles” with a direction that „they must be kept in view while deciding the cases of medical negligence” reflects the judicial attitude of the hon’ble apex court. It may be noted that any decision, judgment passed by the Supreme Court becomes law of the land and is automatically binding on all other lower courts in the country by virtue of Article 141 of the Constitution of India.\textsuperscript{39} Thus the above principles must be taken as „law of the land on medical negligence”. On one hand, these principles provide adequate protection to the doctors and hospitals provided they have exercised a „reasonable degree of care which is neither the highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case.” They give free hand to the doctors to choose from various available alternate courses of treatment/diagnosis, the best course of action which is in the interest and well-being of the patient (consumer). On the other hand, they did provide that „the medical practitioner would be liable only where his conduct fell below of the standards of a reasonably competent practitioner”. Also the decision is progressive in nature as it provides a safety-net to the medical professionals against unnecessary harassment and humiliation which will allow them to perform their duties without fear and apprehensions and would save them from undue pressure for extracting uncalled for compensation. Ultimately the doctors are not the insurers of life. Error in judgment in prescribing treatment so long as it is within the prescribed medical standards should not incur unnecessary liability to the doctor/hospital. This decision would benefit both the parties, i.e. the doctors/hospitals shall not be put to unnecessary harassment and at the same time any casual, careless or negligent performance of professional duty on their part shall definitely hold them liable in negligence. The judgment is likely to ensure welfare of consumers.\textsuperscript{40}

6.5 Implications for the Future:

Public awareness of medical negligence in India is growing. The lucky doctors of past were treated like God and people revered and respected them. With the speed and influence of commercialization and globalization on all spheres of life, even the medical profession has witnessed many ethical and legal challenges in practice.

\textsuperscript{39} Id. para
\textsuperscript{40} Supra note 94
Doctor-patient relationship has undergone swift and adverse changes fuelled by factors such as commercialization of medical practice, ignorance towards medical ethics, zero tolerance and high expectation of patients and the inclusion of health care service within the ambit of Consumer Protection Act.

In the last decades, technical advances in medical field have meant a better quality of life. But it is sad to mention that there has not been a corresponding shift in the standard of medical profession. This article focuses on medical negligence and the Consumer Protection Act in India and its implication on whole of the medical profession.

More and more cases relating to medical negligence are being filed in India after the passing of the Consumer Protection Act, 1986 but then this has also resulted in number of frivolous complaints against innocent doctors. Thus judging the negligence of doctors has become a technical issue. There is an urgent need for the transformation in the doctor-patient relationship to the advantage of patient, doctors and the society at large.

The doctor patient relationship is one of the most unique and privileged based on mutual trust and faith. But presently there is a great decline in the doctor patient relationship. The reason may be communication gap, commercialization of health service, raising expectation from doctors or increased consumer awareness.41

Concept of Medical Negligence
Negligence is the breach of duty caused by omission to do something which a reasonable and prudent person guided by those considerations which ordinarily regulates human affairs would do or doing something which a prudent and reasonable person guided by similar considerations would not do.[1] But the dictionary meaning is ‘Lack of Proper Care’. It means carelessness in a matter in which law mandates carefulness. 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.\textsuperscript{42}

Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch impliedly assures the persons dealing with him that the skill which he professes shall be exercised with reasonable degree of care and caution.

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.\textsuperscript{43}

Deficient system of remedies in cases of Medical Negligence\textsuperscript{44}

After VP Shantha's case it was believed that by providing remedy through consumer forums, availing damages for the injury caused, would become easier for the patients to seek remedy for the wrong done to them. It was considered that this will deter the careless doctors and would thus help in improving the general standards of health services in India. However, the current scenario presents a complete different picture. The numbers of medical negligence suits have grown up by several times in the last 10 years. Considering the objects of COPRA to provide speedy, less expensive, more accessible and simple remedy, it would be difficult to conclude that the act has failed in achieving its goals.

The Complex Procedure for claiming Medical Negligence\textsuperscript{45}

In every complaint of medical negligence the complainant is expected to furnish in the forms of exhibits certain documents to establish a prima facie case. However the

\textsuperscript{42}Id.

\textsuperscript{43}Supra note

\textsuperscript{44}Indian Medical Association vs V.P. Shantha & Ors, 1996 AIR 550

\textsuperscript{45}Id.
patients rarely have access to these medical documents and are generally not delivered to patients especially in cases where something goes wrong on pretext of confidentiality. Thus at this stage it becomes difficult for the patients to establish their case and many cases are dismissed summarily. The procedure that is followed afterwards is equally complex and unnecessarily lengthy involving submission of evidence, examination, cross examination of witnesses and other formalities. Apart from these complexities the trickiest part is proving the negligence of doctor. The test applied for determining liability is the Bolam test, which apart from ‘reasonable care ‘standard also validates the ‘generally accepted practice’ argument. Further there is very little scope for applicability of judicial mind and the direct bearing of this is that the law of medical negligence has not evolved and the principles applicable remain the same irrespective of the fact that medical negligence has progressed in leaps and bounds in this time.

Even the functioning of consumer courts has not been very commendable. This was admitted by Supreme Court in Dr.J.J Merchant v. Shrinath Chaturvedi46, where the PIL questioning the functioning of the consumer courts was filed and the Supreme Court commented that even after the enactment of the CPA, appropriate steps have not been taken by the government for ensuring that the National Commission or the State Forums can function properly. Also the consumer dispute redressal agencies have not been fast enough in disposing cases.

Medical Negligence beyond Compensation47

Merely providing of compensation is not enough to deal with the issue of medical negligence. What is required is a proper mechanism to check to check the cases of medical negligence. One cannot forget that the purpose of law is not just to punish a wrongful act and give remedy to the adversely affected party but also to ensure that such deeds are not repeated again. A complete consumer care system should include steps for prevention of such incidents.

There is lack of effective implementation of the act. The undecided cases have already crossed the statutory limit. The overall performance of judicial and quasi

46 III (2002) CPJ 8 (SC)
47 Id.
judicial bodies can be concluded in one sentence i.e. “Justice delayed is justice denied”. This shows that judiciary has not shown proper concern to cases of medical negligence filed under the CPA.

Though CPA covers broad area of consumer rights but it failed to define service in proper way and failed to give way out to medical negligence cases. Thus there is a strong need of separate act to regulate medical negligence cases and special separate courts for speedy as well as proper justice.

6.5.1 Is it amendment? Or New Act?
With the present study, it is found that there are many loopholes in the Act and the Implementation of the Act. At the same time the application of this act to the Medical Field has impacted doctor patient relationship and the social environment at large.

Impact of application of CPA to the medical field on the society in the form of increased Medical Negligence litigation is as due to following parameters

- Altered Doctor Patient relationship
- Commercialization and Consumerism
- Role of Media in raising awareness
- Declining Professional standards among Doctors
- Lack of good teachers
- Good students are not keen on Medicine
- Technological advancements in the Medical Field
- Lack of infrastructure and adverse doctor patient ratio.

So the real impact on the medical profession is that

- Change in the doctor patient relationship
- Increased practice of defensive medicine
- Rising cost of the treatment
- Loss to the students
- Deficiency in the number of specialists
Though medical professionals tend to blame the CPA for the deteriorating doctor patient relationship, they must introspect and acknowledge the other reasons which are connected to the standards and behaviour of doctors themselves. Medical professionals must realize that the trend of seeking legal intervention to resolve conflict will not subside if they do not change their mode of practice and correct the anomalies that have crept in to the medical profession.

The CPA has been beneficial to aggrieved patients, but it has also damaged medical practice in several ways. The main damage has been the loss of trust of the patients on their doctors. Without trust and faith, it is not possible to build a good doctor patient relationship which is central to successful treatment. Hopefully in the future both doctors and patients will realize the ultimate futility of doctor patient conflict and resolve their grievances amicably, relegating the CPA to the pages of history. 48

6.5.2 Feasibility for the law reform
A new Act named as Patient Protection and Safety Act 2013 is suggested as an Act to provide better protection and safety of patients and for that purpose to make provision for the establishment of Medical Board, other authorities and system of Expert Medical Evidence for the settlement of patient’s disputes and for matters connected there with.

It can exclusively work as Health Tribunal on the basis of limited Fault Based Administrative System and Quick Review Systems for Merit. It will ensure Speedy disposal. It will incorporate views of medical experts on the basis of Daubert’s Criteria and evidence Based Practice of Medical Experts

Further, it will emphasise Patient Safety and quality, thus diffusing the current hostile environment in healthcare stakeholders. More details are provided among suggestions in the following chapter.

6.5.3. Regulations by professional community and Medical Council

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.

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.  

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. 

In the present study, when the doctors and the hospital administrators were asked about,

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49 Code of Ethics Regulations, 2002, Medical Council of India, Chapter 1.2.1
Agreement with the following statement: Rather than the present coverage of doctors under Consumer Protection Act, it is the strict control of doctors’ training by Medical Council of India and quality control by Accreditation bodies which is preferred. The doctors answered in the following way: 59 % of doctors and 61 % of hospital administrators, preferred strict control of doctor’s training by Medical Council of India and regulation by that body while only 6.8 % of doctors and 12.2 % of hospital administrators said no to this concept and remaining were non-committal.

6.5.4 Exclusive Health Tribunals /Medical Boards

Since Medical field is a complex field and uncertainties are quite common, the issue of Medical Negligence should be settled by the authorities belonging to both Medical as well as legal field. This is to avoid the dilution of the legal system that judges the professionals and experts of the Medical Field, by having non experts as judges and use summary procedure or res ipsa loquitur as principle for judging the complicated issues of Medical Negligence.

The system of Health Tribunals and Medical Boards should be established
1. Basis of the system, “Limited Fault based Administrative System”.
2. This being a three tier system, District Medical Boards and State Tribunals as well as National Tribunal needs to be setup.
3. Constitution of Medical Board: should have Medical Experts, legal experts, members of Medical Council and professional organizations
4. Constitution of State Tribunals: Medical Experts, legal experts, members of professional organization and State Medical Councils and retired high Court Judge to guide.
5. Constitution of National Tribunal: Medical Experts, legal experts, members of professional organizations and Medical Council of India, Retired Supreme Court Judge to guide
6. The duration of any Medical Negligence Case should be 90 days only.
7. Three phases for any case: Prehearing, Hearing and limited appellate hearing.
8. Prehearing Phase: Sorting out of the cases that are really cases of Medical Negligence.
9. Hearing Phase: To be heard by Board, expert witnesses to examined and Expert Evidence from registered Medical Experts should be obtained, hearing within 90 days.

10. Limited Appellate hearing: To avoid repetition and only to examine technical aspects again by superior tribunal, within 30 days of the appeal.

11. The decisions of National Health Tribunals should be final with no provision for appeal further. If patient feels aggrieved he should approach Civil Court separately if he wants.

12. There should be cap on compensation.

6.5.5 Review of Medical Curriculum

The Medical Practitioner is an important duty bearer who influences access to justice of the poor, disadvantaged and the vulnerable. ‘A Medical Practitioner can no longer restrict himself to his traditional role of diagnoser of ailments, prescriber of pills and potions and exciser of lumps. His/her role now includes being an educator, counsellor, case finder and an agent of social change’. Dr.K Park.51

Medical Practitioners are one of the crucial neutral expert opinion makers in the Medico-legal cases. The unique Medical Practitioner-patient relationship built on an edifice of mutual trust and respect enables the Medical Practitioner to be privy to the truth regarding both the patient and the facts pertaining to the crime. Diligent clinical examination, appropriate documentation by the Medical Practitioner of the facts revealed by the patient and the findings elicited by him/her provides the scientific evidence. The court seeks the expert opinion of the Medical Practitioner in all Medico legal cases. Further, The Indian Medical Council Act, 1956 in Section 15(2) (C) states that no person other than a medical practitioner enrolled on a State Medical Register shall be entitled to give evidence at any inquest or in any court of law as an expert under section 45 of the Indian Evidence Act, 1872 on any matter relating to medicine. The Medical Practitioner being a neutral (neither a prosecution witness nor a defence witness) expert opinion maker is in a lofty position of having the opportunity to bring to the Court the truth related to the case.

51 Dr.K.Park, as mentioned in DRAFT FOR APPROVAL RESTRUCTURED MEDICO-LEGAL CURRICULUM FOR MBBS COURSE IN INDIA, 2007
Thus, the Medical Practitioner does play a pivotal role in aiding administration of justice in all Medico legal cases. In addition, the trusted position of the Medical Practitioner in the society enables him/her to counsel the patient and the family and offer appropriate guidance for the social, psychological and vocational rehabilitation of the patient.  

The opinion of most practicing Medical Practitioner and also medical students in the country is that they are ill equipped to handle this essential responsibility with the knowledge gained from the present design of the Undergraduate Medico Legal problems. Medico Legal Cases provides an unique opportunity for the Medical Practitioner to play the duty bearer’s role effectively. In all Medico Legal Cases the Medical Practitioner is one of the key neutral experts giving scientific evidence. The unique Doctor-patient relationship built on an edifice of mutual trust and respect enables the Medical Practitioner to be privy to the nearest truth regarding both the patient and the facts pertaining to the disputed issue. Diligent clinical examination, appropriate documentation by the Medical Practitioner of the facts revealed by the patient and the findings elicited by him/her provides the scientific evidence. 

Thus, the Medical Practitioner does play a pivotal role in aiding administration of justice in all Medico legal cases. In addition, the trusted position of the Medical Practitioner in the society enables him/her to counsel the patient and the family and offer appropriate guidance for the social, psychological and vocational rehabilitation of the patient. Thus the Medical Practitioner is an enabler of access to justice. As Harrison said “No greater opportunity, responsibility or obligation can fall to a lot of a human being than to become a physician. In the care of the suffering he/she needs technical skill, scientific knowledge and human understanding. He/ She who uses this with courage, humility and with wisdom will provide a unique service for his fellow men and will build an enduring edifice of character within him/herself. The physician should ask for his/her destiny no more than this; he/she should be content with no less.”

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53 Id.
54 Id.
One of the key neutral experts giving scientific evidence. The unique Doctor-patient relationship built on an edifice of mutual trust and respect enables the Medical Practitioner to be privy to the nearest truth regarding both the patient and the facts pertaining to the disputed issue. Diligent clinical examination, appropriate documentation by the Medical Practitioner of the facts revealed by the patient and the findings elicited by him/her

6.5.6 Assistance and Awareness Generation required among doctors and other stakeholders

The empirical data as extracted below shows the need for the same.

Amongst Doctors

80.1 % of the doctors and 92.7 % Hospital Administrators were aware of the existence of Consumer Protection Act against Medical Negligence.
72.1 % of the doctors and 73.2 % of the Hospital Administrators correctly identified the meaning of Medical Negligence while others were confused with all other answers.
68.9 % of the doctors and 58.5 % of the Hospital Administrators correctly identified the Components of Medical Negligence while others were confused with all other answers.

The participants of the survey were confused over the knowledge of available defences to a doctor in Medical Negligence case. 63.4 % hospital administrators and 22 % of the doctors were aware of the defences available while all others are not aware.
65.6 % of Doctors and 26.8 % of the hospital administrators are insured under Professional Indemnity Insurance.
73.5 % doctors and 73.2 % hospital administrators knew the details of Professional Indemnity Insurance. Remaining participants opted for other options.

The opinion about the knowledge of terms and conditions of Insurance Company was divided in both the groups, doctors and Hospital Administrators. Only 28.1 % of the Doctors and 26.8 % of Hospital Administrators knew the terms and conditions of Insurance Company, in relation to Indemnity Insurance.
40.5 % of doctors and 85.4 % of hospital administrators are aware of the regulations for doctors by the Medical Council of India. It is shocking finding that 60 % of the doctors are not aware of these regulations!

Only 12.9 % doctors and 53.7 % of Hospital Administrators are aware of the amendment of Medical Council of India regulations, remaining are not aware

**Amongst Community**

54.9 % of the respondents know that anybody having any grievance against a doctor or hospital can file a case against doctors in Consumer Courts.

34.1 % said they are not aware of this. 11 % preferred to remain silent on this.

Based on the study findings:

1. Awareness generation is needed among doctors about the law of Medical Negligence and its practical implications.
2. Awareness generation among the community about the patient Rights and Responsibility
4. The community should be aware about the limitations of medical science due to uncertainty beyond human control.
5. Efforts to reduce the enmity between the doctors and the society should be done at national level
6. The information about the new Act, The patient Protection and Safety Act, should be passed on to the community and continuous education programs should be organized for community.

Next chapter summarises the findings, conclusions and offers suggestions for reform.