GENERAL INTRODUCTION AND BACKGROUND

“Without the historical aspects, study of a subject is incomplete. It is said that “History is not only the past remembered but recovered and invented. It is the link between the past and the present, a continuous process, and has to be preserved for the benefit of the future.” History of medical jurisprudence is a part of history in general and a part of the story of progress of mankind through ages.

Dr. J.P. Modi

Man is a social animal. It is believed that, in the primitive society men lived themselves. Neither the government nor the judicial authority existed. One has to protect himself against his wrong doer. With the evolution of civilization, men formed a community to live in peace so that they can be safe from the elements inimical to their safety. The members constituted the government by surrendering their freedoms and the government in return promised to protect the rights and responsibilities of the citizens. As man evolved, the King ruled the State and his subjects by dictating commands.

In modern times, with the development made on various fields, it created a position wherein laws, rules and regulations have to be framed so that all sections of society can live in peace and harmony and take full advantage of the developments in the scientific field. Over the years, the small group of people evolved into larger clusters which further organized themselves into nation states with the specific boundaries. Each nation has enacted its own system of rules and regulation in the form of what is known as “Constitution” which is supreme in transacting affairs of the government and protecting the life and property of its members. The Constitution defines the rights and obligations of the citizens and various organs of the government. Every citizen of the State is expected to obey the Constitution and follow the rules and regulations set out therein.

A medical practitioner is also a citizen and therefore bound to obey the Constitution of the nation. With the object of protecting the interest of the general public and patients in particular, the government has passed various laws for medical practitioners of all branches of medicine such as, the Indian Medical Council Act, the Dental Council Act, Indian Medicine Central Council Act, the Homeopathic Central
council Act, etc. These laws provide for the compulsory registration of medical practitioners with their respective medical councils before practicing in any branch of medicine. Doctors who enrolled with the Council concerned have to follow the rules, regulations and the code of ethics set out by the council. From this, it is clear that, not every person who has graduated in medicine has a right to practice medicine. Not every person who has done diploma or degree in medicine entitles to claim that he has studied medicine. Medical profession is governed by various laws that prescribe standard of education and practice in the interest of public and to maintain high standards of the profession.

A person who does not have the knowledge of a particular system of medicine but practices in that system is a quack and a mere pretender to medical knowledge or skill or put it differently a charlatan. As a rule, a doctor should practice in the system of medicine for which he is registered as a medical practitioner and not any other system of medicine. A registered homeopathy doctor is to practice homeopathy only, as it is a statutory duty not to enter other systems of medicine. If he trespasses into a restricted system, then, he is liable to be prosecuted under section 15(3) of the Indian Medical Council Act. His conduct constitutes “medical negligence” for the injury caused to his patient in practicing system of medicine in which he is not possessed the required skill and knowledge.

1. ORIGIN AND DEVELOPMENT OF MEDICINE AND HOSPITALS
1.1. Indian history of medicine

Although it is very difficult to believe what extent the information discovered in the ancient literature reflects the truth, yet, it is clear from the available document which states that Ayurveda is one of the oldest medical systems in India and finds its origin in Vedic times. Again there is no specific document which mentions when the use of ayurveda first started. There is also ambiguity in identifying the authorities who discovered the traditional medicine, and their understanding of medicine. According to archeologists the people of Indus Valley Civilization in the early Harappan periods i.e., 3300 BC had knowledge of medicine and dentistry. The age of Ayurveda comes somewhere around 2500 to 600 BC in South Asia. Charaka
Samhita\textsuperscript{1} and Susruta Samhita (written in Sanskrit between 1\textsuperscript{st} to 4\textsuperscript{th} Century A.D) are believed to be the most important works in Ayurveda\textsuperscript{2}.

In Ayurveda system of medicine, mainly herbals/plant-parts are used as curative agents in the form of powders, tablets, medicated oils etc. to re-establish a balanced humoral constitution in the body\textsuperscript{3}. Susruta Samhita is attributed as the “father of surgery”, among eight divisions of medical knowledge (Ayurveda) surgery is considered the first and the most important branch. The term Samhita suggests that there existed many such works on surgery in relation to medicine, pediatrics, diseases of the ear, nose, throat, eye and anatomy of human body\textsuperscript{4}. However, as and when time passes, the treatment by way of surgery was neglected by relegating the manual work to lower artisans who were deprived of study of work of Susruta due to their socio-economic conditions. Consequently, surgery declined and reduced to mere theory except for some traditional families who continued to practice\textsuperscript{5}.

Although “Charaka Samhita” as a first treatise on Indian Medicine lays down elaborate code regarding training, duties, privileges and social status of physicians, it does not deal with in respect of liability of a physician towards the patient in the event of any wrong or careless in the discharge of duties. The physician has privileges but no responsibility either towards the State or the patient if something goes wrong. The physicians have been given complete immunity from the court of law. A significant development occurred between 4\textsuperscript{th} and 3\textsuperscript{rd} Century B.C. The “Artha Shastra” of Kautilya was the only law during this period. Penal law started governing the medical

\textsuperscript{1} The term ‘Charaka’ (Caraka) is said to use to ‘wandering scholars’ or wandering physicians’; and ‘samhita, means ‘collected’ or ‘compendium’. The original source is identified as the Agnivesha Tantra based on the teachings of Punar-vasu; Charak is said to have re-enacted this work; and later, another scholar Dridhabala extended it further. The work dates back to the Maurya period (roughly 3\textsuperscript{rd} century BC) Chattopadhyaya, D. (1982) Case for a critical analysis of the Charak Samhita in Studies in the History of Science in India (Ed) Vol.1. New Delhi: Editorial Enterprises pp.209-236.

\textsuperscript{2} According to Ayurveda, health condition depends upon three essential humours or tridoshas (doshas, literally means defects) in the body namely vata (wind), pitta (bile) and kapha (mucous orphlegm). When these humours/doshas are in balance, that is in a state of equilibrium, one remains healthy. The disruption of the equilibrium or imbalance of these three humours in the body causes diseases/disorders. Valiathan, M.S. (2003) the Legacy of Caraka Orient Longman reviewed in Current Sciences, Vol. 85 No. 7 Oct 2003, Indian Academy of sciences p 36.


\textsuperscript{4} Chari PS, ’Susruta and our heritage’, Vol. 3, Indian journal of Plastic Surgery, 2001, p.82.

practice and utilized medical knowledge for the purpose of law. Physicians directed
to secure from the King express permission before practicing medicine and their
practice was regulated and they were made liable in the case of maltreatment or
negligence.6

During medieval period, India was subjected to invasion by foreign powers
like the Turks and the Mohammedans as a result of which culture and civilization of
India suffered a serious set back. Then the Portuguese, the Dutch, the French and the
British also invaded this country and ultimately the Britishers ruled over the country
from middle of the 18th Century to middle of the 20th Century. The legal, medical and
medico-legal systems of Great Britain prevailed in India and Medical Jurisprudence
was taught in the medical schools and colleges.7 In 1822 the Medical School was
established at Calcutta and converted to a Medical College in 1835. Similarly, such
institutions were also established at Madras, Bombay and other places. The Indian
Penal Code came into existence in 1860, the Criminal Procedure Code in 1861 and
the Indian Medical Council was established in 1933.8

1.2. Mesopotamian medicine

Mesopotamian medicine arose and developed in the eastern Mediterranean
civilizations in the period of 5000 to 3000 BC.9 The healing practice was dominated
by superstitions where sickness was attributed to some supernatural forces. Illness
was viewed as punishment sent by the stars for violating taboos, social rules, or as
intentional inflections of witchcraft, demons, and malevolent supernatural forces. In
this ancient era, there was a strong belief in the supernatural that is, supernatural
forces were considered as cause of diseases and therefore, supernatural means were
used as diagnostic methods, and treatment was supernatural in character.10 For
instance, Gods and ghosts were blamed for causing diseases and malfunctioning of
organs. It can be shown that plants were used in treatment and sometimes, specific

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6 Mujamdar, A.B, Forensic Medicine in Ancient India, The Indian Police Journal, July 1959, Vol. VoI,
No, p. 6-9.
7 Das Gupta, S.M, Forensic Medicine in India – Its Past, Present and Future, Medical News Medicine
&Law, July 1981, Vol. XII, No. 1, p. 7-14/
8 Modi’s Medical Jurisprudence and Toxicology, Franklin C.A, (Ed) 21st edition, Tripati Private
10 www.pipl.com/directory/people/Arturo/castiglioni-9k, visited on 16-08-2008.
offerings were made to particular God or ghost when it was considered to be a causative factor\textsuperscript{11}. It is supernatural element that distinguishes primitive medicine from modern medicine. The healing practice of this kind what is known as “magic medicine”.

There were two distinct types of medical practitioners in ancient Mesopotamian namely Ashipu (Sorcerer) and Asu. One of the important functions of the ashipu was to diagnose the ailment. For any internal diseases, the ashipu was able to identify God or demon which was causing the illness and also tried to determine if the disease was the result of some error or sin on the part of the patient. The ashipu attempted to cure the patient by driving out the spirit causing disease\textsuperscript{12}. In case ashipu could not cure disease, he would refer the patient to a different type of healer called an “Asu” who was a specialist in herbal remedies and frequently called “physician” in older treatment of Mesopotamian medicine. This specialist used to cure disease with empirical application of medication e.g. treating wound with three fundamental techniques: washing, bandaging and making plasters\textsuperscript{13}. However, the relationship between the Asipu and Asu is not clear, the two kinds of healers seemed to have worked together in order to obtain cure. The wealthiest patient used to take medication from the Ashipu and Asu in order to cure an illness. It seems that the Ashipu and Asu used to work in co-operation with each other in order to treat certain ailment\textsuperscript{14}. Later, Assyrian and Babylonian doctors became famous and popular to the extent that they could charge high fees like Egyptian doctors. There were no laws except medical texts containing descriptions of various diseases and corresponding prescriptions. The Code of King Hammurabi of Mesopotamia (1792 BC), recognized the doctor’s important role in the society and became most significant document expounding medical ethics. The Code of Hammurabi fixed the medical practitioner’s liability and medical fees for various diagnosis and treatment.

1. 3. Egyptian Medicine

The ancient Egyptian Medicine emerged as parallel and independent medical practice of Mesopotamia. The medical information contained in the Sir Edwin

\textsuperscript{11} www.indiana.edu/ancmed/meso.HTM visited on 16-08-2008.
\textsuperscript{12} Ibid.
\textsuperscript{13} www.mic.ki.se/mesop.html \textsuperscript{14} k
\textsuperscript{14} www.eduhlper.com/reading/comprehension42_181_html. visited on 16-08-2008.
Smith Papyrus provides detailed description about the method of cures, ailments and anatomical observations. The earliest known surgery was performed in Egypt around 2750 BC. Although in ancient Egypt treatment was influenced by supernaturalism, yet it introduced rationalization of patients’ diagnoses and diseases, patients were carefully examined, case histories were maintained and tests of urine faeces and blood were invented. Egyptian physicians were known for excellence and skill in the mummification processes, the tombs and other monuments. They rejected the theory of disease-causing demons, and other superstition. However, these physicians were members of priestly class as a result; religion played a vital role in the Egyptian medicine and importance of medicine declined after Persia conquered Egypt. Along with contemporary ancient Egyptian medicine, the Babylonians introduced the concept of diagnosis, prognosis, physical examination and prescription. One of the oldest medical texts on medicine written by the physician during the reign of the Babylonian King around 1069-1046 BC is the Diagnostic Handbook that introduced the methods of therapy and the use of empiricism, logic and rationality of diagnosisi, prognosis and therapy. The symptoms and diseases of a patient were treated through therapeutic means such as bandages, creams and pills.

1.4. Jewish Medicine:

In the eighth century BC, a thousand years after Hammurabi, the ancient Jewish medical text can be found in Old Testament in the book of Moses which contain various health related laws and rituals, such as isolating infected people, washing after handling a dead body, and burying excrement away from camp. While the observance of these rules leads to maintain good health, Jewish people believed that these commands to be followed purely to fulfil the will of God. The

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15 Sir Edwin Smith (1883-1969) a contemporary of Sir Bernard, Spilsbruy, having studied in Edinburgh, came to Egypt and pioneered the scientific investigation of medicine in Egypt. He also wrote a text book of medicine and law which was edited by Taylor’s Principles and Practice of Medical Jurisprudence. (Modi’s Medical Jurisprudence p. 23).
20 Leviticus 13:45-46.
23 Max Neuberger, writing in his “History of Medicine” says
self-exile prophets, especially Amos\textsuperscript{24}, Jeremiah\textsuperscript{25} and Isaiah\textsuperscript{26} delivered a powerful message of justice and righteousness to kings and nations to follow the straight and narrow path. Centuries later, by this beginning of the Talmudic period\textsuperscript{27} this ethical message was included in the medical profession which enjoyed the same status as priests and judges at that time. The medical calling gained favour both in the sight of God and man\textsuperscript{28}. The doctors were also granted privileges and their liabilities were carefully expounded and restricted. The crux of Jewish medicine lies in the concept of monotheism and Old Testament gives valuable contribution to the development in terms of social ethics and social hygiene until the relevant legislation was enacted\textsuperscript{29}.

1. 5. Chinese Medicine

The origin of Chinese medicine dates back to the Chinese civilization which took place before the reign of great Emperor Fi, who reigned about 2800 BC. Chinese medicine which created a revolution in the treatment of diseases stagnated completely about AD 1000, due to the overemphasizing of detail and deletion of fundamental facts. However, at about 2700 BC the therapy of acupuncture and moxibustion had been invented\textsuperscript{30}. Later, Chinese medicine spread to Japan through Korea about AD 400 where Chinese doctors were invited to open first Japanese hospital in 758.

1. 6. Ancient Greek medicine (Allopathy)

As the societies developed in Europe and Asia, the system of belief was replaced by a different natural system. The contribution by Hippocrates to the modern

\textsuperscript{24} The book of Amos 7:14; 5: 23-24.  
\textsuperscript{25} The book of Jeremiah 23:28; 33:15.  
\textsuperscript{26} The book of Isaiah 32:1; 5:15; 33:16.  
\textsuperscript{27} 200 BC to AD 600.  
\textsuperscript{28} The book of Ecclesiasticus 38: 1-3.  
\textsuperscript{29} Medicine of ancient Persia and India also emerged and was migrated into Mediterranean basin between 3000 and 1000 BC. It spread to distant places but was later almost completely destroyed and is today maintained only by oral tradition. It consisted mainly of the belief of a demonstic origin of all ills and healing was perceived as a magical experience which changed into a religious ideation. Castiglioni Medicine p. 80-97.  
\textsuperscript{30} www.wikipedia.org/wiki/traditional_chinese_medicine-155k
medicine is most outstanding. Besides other things the “Hippocratic oath” as a part of Medical law and Ethics still holds dominant place in today’s medicine\textsuperscript{31}. Hippocrates (460 – 355 BC) who is widely regarded as the “father of Western/modern medicine” and his followers were first to describe many diseases and medical conditions such as symptoms of lung disease, lung cancer and cyanotic heart disease. By believing that the cause of all illness was natural forces like hot, cold, dry, or damp, Hippocrates categorizes illness as acute, chronic, endemic and epidemic, and uses terms such as, “exacerbation, relapse, resolution, crisis, paroxysm, peak and convalescence”\textsuperscript{32}. However, the supernatural stigma and speculations were exchanged for rational considerations of scientific value, such as the clinical observation of patient which created a consistent doctrine of theory and practice. Physicians were classified as belonging to the class of ‘demiurgoi’ (the workers useful for the people). Medicine was prepared by the physician himself or by his assistant who later became pharmacists. Midwives appeared and a textbook of midwifery was also brought into light\textsuperscript{33}. The Greek medicine stands out in the history of medicine. This period was characterized by rational investigations of life itself and an unequalled search for new knowledge. From these facts scientific medicine arose.

\textbf{1. 7. Roman Medicine}

Greek medicine migrated into Rome in 292 BC during a major epidemic. The Romans initially bestowed little or no honour on their own physicians, because of low status they enjoyed on the premise that the method of treatment had direct connection with Greek goddess and it was suitable to only slaves, freemen and foreigner. When Romans conquered Greece in 146 BC, then, they accepted the superior quality of Greek doctors in healing diseases, for instance, Asclepiads of Prussia who came to Rome in 100 BC detected sign of life in a corpse which was on its way to be buried after investigation, he manipulated the body and brought it back to life. He became well known. This acceptance led to the spread of Greek medical theories throughout

\textsuperscript{31} The Hippocratic Corpus contains the core medical texts of this school. Although once though to have been written by Hippocrates himself, today, many scholars believe that these texts were written by a series of authors over several decades. Since it is impossible to determine which may have been written by Hippocrates himself, it is difficult to know which Hippocratic doctrines originate with him. \textit{www.wikipedia.org/wiki/ancient_greek_medicine-10k}

\textsuperscript{32} Supra n. 16.

\textsuperscript{33} Castiglioni Medicine 146.
the Roman Empire, and thus a large portion of the West\textsuperscript{34}. On the basis of Hippocratic medicine, Romans came up with one of the best and most sophisticated Medical System of the ancient world. Ancient Roman Medicine comprised of neither scientific technique nor supernaturalism, rather, it can be said that it was a combination of both\textsuperscript{35}. Romans believed that diseases happen as result of disliking of Gods. For the purpose of get rid of disease, they resorted to transcendental practices such as superstition and rituals. Many diseases were healed; therefore, they believed that they should please the Gods by performing the correct religious and spiritual acts. Still it was trial and error process.

Romans invented numerous surgical instruments such as forceps, scalpel, cautery, cross-bladed scissors, surgical needle, sound and specula to perform surgery. After assassination of Julius Caesar, then emerged Emperor Augustus established professional military hospital for treating gladiators and soldiers and realizing the doctor’s role in his empire conferred on all physicians dignified titles, land grants, special retirement benefits, with the result of which the status of practice medicine was enhanced\textsuperscript{36}. The medical profession lost its shoddy treatment and became respectable. The Romans later, established general hospitals and schools to study medicine scientifically and become practitioner. The state employing physicians and specialists began to emerge\textsuperscript{37}.

Like modern medical practice, ancient Roman medicine was classified as different specialists such as internists, ophthalmologists, urologists, dentists, midwives and nurses. All surgical tasks were performed by appropriate specialists. As a result, some doctors charged excessive prices for the worthless medicines and drugs and others attempt to deal with and treat diseases without understanding properly. There were licensing boards but no formal qualification prescribed for entering into the profession. Any one could call himself a doctor. If his methods were successful, he attracted more patient, if not, found himself another profession\textsuperscript{38}.

\textsuperscript{34} www.wikipedia.org/wiki/pedia/rome_medicine_20k visited on 17-08-2008.
\textsuperscript{35} www.legvi.tripd.com/id30.html-19k visited on 17-08-2008.
\textsuperscript{36} www.unrv.com/culture/roman-medicine-php visited on 17-08-2008.
\textsuperscript{37} www.crystalinks.com/romemedicine.html, Visited on 17-08-2008.
\textsuperscript{38} Ibid.
1.8. Emergence of Christians

In the early centuries of Christianity plagues occurred frequently and were extremely contagious, causing enormous loss of human life. It was reported that around 8,00,000 people died of one plague in Numidia alone. It has been cited as a major factor in the decline of the Roman Empire. It was however, during the time of these epidemics that Christians first established institutions to care for the aged and the sick. The institutions referred to as hospitals and pharmacies were instituted separately for soldiers, slaves, athletes and for wounded gladiators and for the legions. Well known doctors like Galen, used to attended all sorts of patients.

1.9. Medicine in the English Middle Age: Institutionalization of hospitals

After the fall of Rome, especially 600 AD onwards, European medicine was dominated by the Church which believed that illness stems from sin, the devil or witchcraft and the only way to be protected from the disease is prayer or praising and worshipping Lord Christ. As a result of prayer, if the disease is recovered, the same will be perceived as a miracle. Any medical practitioner, who renders medical service outside the authority of the Church, is charged with interfering with the will of God. If any success is achieved by a practitioner other than the authority of Church, it is viewed as a success obtained through the help of the Devil and is called ‘witch’. The cure itself is perceived as evil by the Church. The Church as a dominant factor, established many hospitals throughout the Middle Ages. History reveals that Christians founded the first hospitals as a result of duty they perceived that they had to serve their fellow man. Around 700-950 AD, they established universities and

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39 Circa 100-300 AD.
40 Castiglioni Medicine p. 244.
42 Galen (130 – 201 AD) (full name was Claudius Galenus) was the Greek physician, who lived in the second century whose medical findings influenced western medical science for nearly 15 centuries. Wrote extensively about the body’s four humours: blood, phlegm, black and yellow bile. Galen made complex mixtures of herbs, animal parts, and minerals, galenicals. First gained fame as a talented surgeon who put gladiators back together again in Alexandra. Galen believed that everything in the universe was made by God for a particular purpose. This search for God’s design not only in the universe but in the human body made his work and writings appealing and popular. (The Hindu October 29, 2006, young world p. 2.)
43 AD 500-1500 (Peters JD, Law of Medical Practice, Health Administration Press, Institute of Continuing Legal Education, Michigan USA 1981, p. 3)
44 Prior to the medieval period and its hospitals, we find that temples were probably the first institutions concerned with the sick. Religious traditions of ancient Judaism, Christianity and Islam have been mentioned to have had a distinct influence in this regard: see Carmi Amnon, Hospital Law, Springer Verlag, New York, 1987 p. 7.
taught medicine based on Greek philosophies\textsuperscript{45}. The establishment of hospitals during the Middle Ages is considered the greatest medical accomplishment of that period. However, Jewish hospital, which existed in the pre-Christian Talmudic period, has been mentioned as a possible model for the Christian institutions. Hospitals and universities were owned by the Church and others on the order of the Church. Small hospitals where ancient medical knowledge was practiced restricted at first and eventually forbidden by the Church\textsuperscript{46}.

These medical hospitals were philanthropic and spiritual institutions which offered hospitality to the socially unfit, that is the mentally ill, the disabled, the aged, the poor and homeless rather than being acclaimed for their medical treatment\textsuperscript{47}. These hospitals were small, overcrowded, under-equipped, and mainly the place where sick people died. In view of this, the first hospitals in England were established during the middle Ages under the influence of the Christian church. St. Bartholomew’s Hospital was founded by a clergy in London in 1123 with assistance from both the king and the bishop which is still in operation today\textsuperscript{48}. In France\textsuperscript{49}, Italy\textsuperscript{50}, Germany\textsuperscript{51} and old Mexico\textsuperscript{52} American continent, hospitals were established and owned by the Christian Church during the Middle Ages\textsuperscript{53}.

For long centuries from the fifth to fifteenth, the godly, anti-science stance of the Church had stood as stumbling block in the way of the development of scientific medicine. Medicine founded by Hippocrates suffered setback during the middle ages. During this period the dogmatic views of Galen dominated medicine and any departures from his teaching were often treated with great ruthlessness by ecclesiastical authorities. Religious fanatics destroyed the library at Alexandria and during the middle ages men of learning were persecuted, dissection of the human

\textsuperscript{45} Peters, Law of Medical Practice, p. 3.
\textsuperscript{46} Castiglioni Medicine 298-299: (1131-1212 AD)
\textsuperscript{47} Carmi, Hospital Law, p. 7.
\textsuperscript{49} Paris during 12\textsuperscript{th} century.
\textsuperscript{50} Padua during 13\textsuperscript{th} century.
\textsuperscript{51} Bologna during 12\textsuperscript{th} century.
\textsuperscript{52} 15\textsuperscript{th} century.
body forbidden a sinful and the primitive idea that disease was a punishment for sin revived\(^{54}\).

### 1. 10. The Renaissance\(^ {55} \): Professionalization of medicine

The **sixteenth century** gave birth to scientific psychopathology, a new epidemiology, and the application of chemistry to medicine\(^ {56}\). King Henry VIII awarded the medical profession in England a professional status of exclusive standing, laying down strict conditions for the examination of and entering into the medical practice\(^ {57}\). For this purpose, an ‘Act of concerning Physicians & Surgeons’ of 1512 was passed. Stressing the dangers caused by quacks and charlatans, the university doctors petitioned the State to delegate control over medical licenses and practice\(^ {58}\). In 1518, subsequent Act was enacted in the form of the *Royal Charter of Incorporation*, establishing a governing body regulating the profession which later became the *Royal College of Physicians of London*. These laws under which the Bishop of London retained ultimate jurisdiction decided who could practice in the city and within a seven mile radius therefore, forbidding unlicensed or domestic practice\(^ {59}\). The exclusivity and status of the medical profession were thus procured at a very early stage by an elite sector of society. People involved in politics, economics and law were firmly convinced of the value of the services rendered. They sponsored the medical profession and ensured its steady progress since the establishment of the universities. These legislations and subsequent statutes had a lasting effect on the medical profession even in the nineteenth and twentieth century.

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\(^ {54}\) Arnold Mann, Medical Assessment of Injuries for Legal Purposes, 2\(^{nd}\) edition, Butterworths, 1971 p. 31.

\(^ {55}\) Beginning circa 1500: The Renaissance

\(^ {56}\) Desiderius Erasmus (1466–1536), a philosopher and writer was the first person to write that *"prevention is better than cure"*. Erasmus was actually referring to education as a method for preventing human conflict, rather than talking about natural health. [www.naturalhealthperspective.com/tutorials/history.html-53k](http://www.naturalhealthperspective.com/tutorials/history.html-53k), visited dated 18-08-2008.


\(^ {59}\) Ibid.
1.11. The Reformation \(^{60}\)

At the beginning of the \textbf{seventeenth century}, health care in England has been classified into three categories namely the physicians, the surgeons, and the apothecaries. Physicians who hailed from the upper-class and economically strong possess a university degree, surgeons in contrast, are typically apprenticed and hospitals trained and often perform the dual role of barber and surgeon, whereas, apothecaries are learned in prescribing, making and selling medicines with apprenticeships. However, by the end of seventeenth century, the Europe witnessed the development of physiology and microscopic anatomy; discovery of circulation blood and advances in respect of knowledge about digestion, respiration, pathology, surgery and clinical medicine. As a boon to medicine, the first hospital came into existence in the major cities of the United States and Canada. With the popularity of medicine, quack practitioners also increased throughout Europe and Colonial America. Members of the public preferred to trust unlicensed domestic practitioners, whose reputation was often more reliable. In post-revolutionary America, state legislators were less concerned with delimiting exclusive rights to practice health care than ensuring that the various groups trained their practitioners to be competent and skilful. Indeed it was repugnant to democratic institution of America. Hospitals were understaffed, overcrowded and too small. The Church lost its position as Europe’s indisputable moral authority in controlling medicine. Inspite of this, seventeenth century health practice experienced a co-operation of medicine and natural sciences, introduced experimental medicine, initiated the exchange of international medical discoveries and other important medical information, set the way for the further development of modern medicine while increasing dignity and social status of physicians who enjoyed more respect and adoration in society.

1.12. The Enlightenment \(^{61}\)

The \textbf{eighteenth century} also witnessed a tremendous progress in the establishment of hospitals across the world. Providentially, the political and social situation favoured the development of health care institutions. In England the eighteenth century was a very prosperous time due to the emergence of

\(^{60}\) The 1600s-the Reformation: a movement in Western Europe that aimed at reforming some doctrines and practices of the Roman Catholic Church and resulted in the establishment of Protestant churches.

\(^{61}\) The 1700s - The enlightenment.
industrialization and rapid growth of trade and commerce. It has been called the ‘Era of Health care Institutions’ as private entrepreneurs ventured into the public health sector. Indeed many hospitals were established in Great Britain from the middle of the eighteenth century in particular. Similarly, in North America, state and local authorities established institutions which primarily housed those with infectious diseases, the poor, destitute and the homeless and later these institutions were called “hospitals”62. In France, the government took over all hospitals at the time of the French Revolution and handed supervision over to the municipalities63.

During the eighteenth century great development took place in the field of chemistry64. But ‘heroic medicine also prevailed which was known for its extensive bloodletting and the prescribing of dangerous mineral drugs65. Homeopathy66, eclectic medicine67 and

Thompsonism68 arose in response to heroic medicine. Vaccination was invented by Dr. Edward Jenner, an English physician69.

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62 The Pennsylvania Hospital founded in 1751 by Benjamin Franklin, the present Philadelphia General Hospital started in 1731, the Bellevue Hospital in New York started in 1735, the New York hospital started in 1771, Dispensaries were established in Philadelphia in 1784 and New York in 1791. (Annas G. Rosenblatt R & Wing K, American Health Law, Little Brown, Boston 1990, p. 10).


64 Peters, Medical Practice p.5. Castiglioni Medicine p.580: Oxygen and other gases were discovered.

65 Reader’s Digest Universal Dictionary 1988, 737; ‘ A system of medical treatment based on the use of minute quantities of remedies that in large doses produce effects similar to those of the disease being treated.’ In America probably the most famous victim of heroic medicine was George Washington who bled and poisoned to death by physicians on December 14, 1799.

66 Homeopathy is an alternative system of medicine, based on the nature’s Law of Cure namely ‘Like cures Like’. This law was discovered by a German scientist Dr. Samuel Hahnemann in 1796. Homeopathy differs considerably from other systems of medicine in diagnostic and treatment procedures. It goes into the details of patient’s history before starting the treatment. The procedure of Homeopathy treatment is slow, but is claimed to remove the disease/disorders from its roots. (Career in Homeopathy, Selvam ABD, Employment News Weekly, New Delhi, 07-13 April 2006 p.1)

67 ‘Eclectic medicine was another medical movement of the era, developed by Worster Beach, a medical school graduate who also studied with botanical practitioners. Beach used vegetable remedies and rejected mineral drugs and bloodletting. www.wikipedia.org/wiki/Eclectic_medicine-31k dated 22-08-2008.

68 The Thomsonian sect-whose therapy was based on the curative effect of herbs, emetics, and heat application. www.wikipedia.org/wiki/Thomsonian_medicine-12k dated 22-08-2008.

69 Dr. Edward Jenner, inventor of vaccination discovered mechanical technique to treat smallpox disease which was rampant during most of the eighteenth century. www.oxblog.com/article/14/dr-edward-jenner-the-inventor-of-vaccination-and-vaccines.html dated 24-08-2008.
1.13. The Birth of Modern Medicine

The nineteenth century witnessed further development of different sciences and technological invention in medicine resulting in unprecedented information concerning the human body. Most important of all, the number of hospital came into existence in the nineteenth century and indeed flourished. This was due to rapid growth of urbanization as a consequence of Industrial Revolution. Clinical observation and autopsies were performed because of newly invented medical technology and facilities available in the hospitals. Hospitals had sufficient number of medical and sanitary personnel, materials and other resources. During the nineteenth century, Rene Laennec\textsuperscript{70} invented the stethoscope, Vincent Priessnitz\textsuperscript{71} introduced hydrotherapy, Louis Pasteur\textsuperscript{72} and Robert Koch \textsuperscript{73} discovered preventive vaccines against anthrax, chickenpox, cholera and rabies, Joseph Lister\textsuperscript{74} invented antisepsics, Morton and Long\textsuperscript{75} anaesthesia and Osteopathy\textsuperscript{76} and preventive medicine were developed. Doctors’ diagnoses were based on scientific grounds rather than moral inclinations. Women were accepted into some medical schools as early as 1847, but only in the 1870s this became a common phenomenon when women also entered several others predominantly ‘male professions’\textsuperscript{77}. In America all hospitals of the nineteenth century were institutions for the poor. Medical care was mostly administered to the poor at home or at the physician’s office. Because of the appalling circumstances in the hospitals where unhygienic conditions prevailed, wards were overcrowded and where there was a general lack of medical skill and knowledge, only the desperate sought refuse there. The doctors therefore had

\begin{itemize}
  \item \textsuperscript{70} High-tech (allopathy) medicine first started when Rene Laennec invented the stethoscope in the year 1816. Earlier doctors used to observe patients.
  \item \textsuperscript{71} (1829)Vincent Priessnitz a Germany physician who is called the” father of hydrotherapy” founded the treatment of disease by means of water. \url{www.naturalhealthperspective.com/tutorials/history.html-53k}
  \item \textsuperscript{72} In 1864,Louis Pasteur give the world the germ they of disease developed in inoculation to prevent rabies. \url{www.dinodima.com/sicne/title=louis++pasteur}, dated 28-08-2008.
  \item \textsuperscript{73} In 1876, Robert Koch discovered in Germany that anthrax was caused by a specific bacterium, at a time when people still thought that most diseases were caused by poisonous bad air. This event marks the official birth of preventive medicine.
  \item \textsuperscript{74} 1867, Joseph Lister like Louis Pasteur explored the inflammation of wounds at the Glasgow University, for this reason he is called the “Father of Antiseptics”. (Hardinj Rains, A.J, Joseph Lister \& Antiseptic, East Sussex, \textit{2nd} edition, 1978, p. 69)
  \item \textsuperscript{75} In 1864, anaesthesia was invented by Morton and Long and was considered as Amercian invention. Thereafter, the development of new modules (cocaine, hexobarbial) which can be considered by other ways (spinal puncture, intravenous injections) allowed new methods of anestheisa to be achieved. \url{www.ncbi.nlm.nih.gov/pubmed/9657020}, visited on 28-08-2008.
  \item \textsuperscript{76} The practice of osteopathy began in the US in 1874. The term “osteoopathy” was coined by Andrew Taylor who developed the practice of Osteopathy. \url{www.wikipeida.org/wiki/osteopathy}.
  \item \textsuperscript{77} Peters Medical Practice p. 6.
\end{itemize}
little contact with private or public hospitals and surgery was performed elsewhere than in hospitals\textsuperscript{78}.

The nineteenth century saw scientific breakthroughs introducing antiseptics, anaesthesia, X-ray diagnosis, modern medicine and sophisticated surgical techniques. These revelations procured the American hospital’s role in the training of physicians under tutelage of leader physicians, and the hospitals claimed the free services of physicians to patients in wards. Physicians considered unethical to charge patients in wards, only charged private patients who sought physicians with good reputations for hospitals. The evolution of hospitals also influenced the nursing profession. Florence Nightingale brought about revolutionary changes in the health-care service during the Crimean war. The emergence of nursing profession is another major development\textsuperscript{79}. In 1851, as there were an estimated 6000 unlicensed medical practitioners operating in the U.K but only 5,000 regular, qualified, doctors, apothecaries and surgeon, the British Medical Act of 1858 was passed which provided that no one could practice medicine without accredited licenses and such licenses were granted only to those with the approved qualifications.

1. 14. Sophisticated Standard of Medicine

Twentieth century medicine proves sophisticated and high standards of medical treatment around the world. Every field of medicine which was known subjected to further investigations and unexplored field of medicine has also been investigated. Modern medicine and modern physicians have been proved successfully in administering life saving drugs on millions of lives. However, the modern medicine, modern hospitals and modern physicians/surgeons are confined to only large urban areas than the rural areas. Neither the states nor private charities or enterprises or religious groups have extended their health care facilities to the remote corner of the countries. Hospitals which once existed as dying place have become haven for patients. The health-care industry has become the subject of national economic and has been expanded beyond the national boundaries. These revolutionary changes in the health care sector would not have been achieved without the constructive support of the governments, social and economic status, and

\textsuperscript{79} Pozgar George D, Health Care Administration, Jones and Bartlett , 1999 p. 299.
advancement of technologies at the national and global sphere. On the other hand, the
twentieth century has also witnessed deterioration of physician-patient relationship,
shift of fiduciary notion into the service provider and consumer, commercialization of
health care institutions, erosion of medical ethics in the practice, frequent litigations
against the health care providers, non-recognition of Bill of Rights of patients and
lack of adequate mechanisms to enforce the legal liability of the healthcare providers.

1.2. LEGAL DIMENSION OF MEDICAL PRACTICE

In India there are several pieces of legislations which permit self regulation in
maintaining the professional standards in imparting proper training, determining
medical qualifications, granting of permission to practice and in enforcing discipline
among the practicing medical practitioners of allopathy, ayurveda, siddha, unani and
homeopathy, dentists, the nursing staff and the pharmacists.

1.2.1. The Indian Medical Degrees Act 1916

The Indian Medical Degrees Act 1916, seeks to govern practitioner who are
practicing Western system of medicine such as allopathic medicine, obstetrics and
surgery but excludes the practitioners of homeopathic, ayurvedic or unani system. The Act imposes bar on unauthorized granting of degrees and makes its violation as punishable with fine which may extend to five hundred rupees. The Act provides that no court shall take cognizance of an offence publishable under this Act except by the order of the State government, or upon a complaint made with the previous sanction of the state government, by Council of Medical Registration established any enactment. The Council does not have suo moto power to take action against anyone who contravene the Act. There are no guidelines as to proceedings to be conducted by the State government in the case of complaint lodged by the Council.

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80 The Indian Medical Council Act 1956
81 The Indian Medicine Central Council Act 1970
83 The Dentists Act 1948.
84 The Indian Nursing Council Act 1947.
85 The Pharmacy Act 1948.
86 Section 2 of IMDA 1916.
87 Section 4 of IMDA 1916.
88 Sections 5 and 6 of IMDA 1916.
89 Section 7 of IMDA 1916.
The Act by and large is to be operated at the sweet will of the state government. The Act has failed to maintain discipline and uphold the honour of the profession.

1.2.2. The Indian Medical Council Act 1933

For the first time, the Medical Council of India was established in 1934 under the IMC Act of 1933 with the objectives of maintaining uniform standard of medical education in India, regulating the entry of new entrants, recognizing medical academic qualifications and having reciprocity with the foreign countries in the matter of mutual recognition of medical qualifications. However, with the phenomenal growth of medical education in India after independence, it was felt that the provisions of the Act were inadequate to meet the new challenges. Thus, the Indian Medical Council Act 1933 was repealed and the new enactment namely the Indian Medical council Act 1956 was enacted.

1.2.3. The Indian Medical Council Act 1956

After independence, the state governments established medical councils by enacting the Medical Act for the enrolment of medical practitioners and controlling of medical education in their own states. However, registration was not compulsory under the different State Medical Acts except the Bombay Medical Practitioner’s Act 1938 which makes registration compulsory and debars persons from practicing or holding themselves out as practicing for personal gain, any system of medicine, surgery or midwifery in this State. IMC Act 1956 provides for the Medical Council Act of India which shall consist of nominated as well as elected members from amongst the medical practitioners. The Medical Council recognizes the medical qualifications granted the medical institutions in and outside India and is empowered to maintain a register of medical practitioners. The Council is also authorized to prescribe standards of medical education including post graduation for the guidance of universities and may advise universities in maintaining uniform standards for medical education throughout India.

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90 Amended Act of 1950.
91 Section 4 and 5 of the IMC Act 1956.
1. 2. 3. A. Rights of registered medical practitioner

A registered medical practitioner is entitled to hold official appointments, to sign birth, death or other medical certificates required by law, 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, surgery or midwifery, and to be exempted from serving on a jury and at an inquest. However, there is no mandatory obligation on any medical practitioner to examine, treat or give aid to a stranger, whether in an emergency such as a road accident or otherwise. Therefore, he cannot be held liable for refusing or failing to treat or arrange for treatment of a person with whom he is not and never had been in any kind of professional relationship. If the doctor is called by the police in the event of an accident, he may render first aid and advice, but no doctor-patient relationship is established. A doctor is not obliged to attend a case, if he does not want to; he can be criticized but he is entitled like any other professional to say he cannot attend to a case. Nevertheless, a medical practitioner should extend his service in an emergency especially in a situation where there is no suitable medical aid is available; refusal to attend such case would be viewed as gross breach of his ethical obligations. A medical practitioner serving in any charitable or general hospital is bound to render professional services to every patient who approaches the institution for treatment.

1. 2. 3. B. Infamous conduct and Disciplinary control

Although the State Medical Council is empowered to take disciplinary action against medical practitioners after due investigation into the alleged infamous conduct, the council does not have power to take action on its own unless affected person files complaint in writing. What amounts to infamous conduct or professional misconduct depends upon the standards of professional conduct and etiquette and code of ethics as set by the Medical Council of India. If the allegation of professional misconduct is proved, a medical practitioner’s name can be removed from permanently or for certain period of time from the Register. However, to prove the complaint, the disciplinary committee medical council shall apply a high standard

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94 Lancet, 15 March 1930, p 602.
95 Supra 86.
96 Section 20A read with section 33(m) of the Indian Medical Council Act 1956.
of proof and not mere on preponderance of evidence\(^{97}\). Such high standard of proof results in heavy risk on the part of the complainant. The complainant has to show that the medical man has done something which is disgraceful or dishonourable to the reputation of the profession. But what conduct of the medical man brings in disgraceful to the profession is not defined in the Act. As a result, it raises a series of question whether the lack of adequate knowledge of medicine, negligence resulting in injury to the patient, charging of excessive fee for rendering service, or refusal to treat or failure to achieve desired result, or mismanagement of affairs of the medical council can be viewed as disgraceful to the reputation of profession. In 2001, the Delhi High Court ordered removal of then President of the Medical Council of India and directed the CBI to initiate prosecution against him for his involvement in corrupt practices while observing that the apex body for doctors was a ‘den of corruption’. The court observed that first step to be taken is removal of the president from the office of the MCI\(^ {98}\). Under this circumstance, can the medical council initiate disciplinary action against the president of its own institution?

1.3. ETHICAL DIMENSION OF MEDICAL PRACTICE

Every system of medicine has its own disciplinary code to maintain professional conduct and etiquette among its members. Hippocratic Oath is the first code in dealing with the conduct of medical practitioners followed by the International code of Medical Ethics 1948\(^ {99}\). The Medical Council of India is authorized to frame rules and regulations in relation to Professional Conduct, Etiquette and Ethics for registered medical practitioners. Any violation of the code of conduct by any medical practitioner would lead to the charges of misconduct and if proved he may be debarred from practicing medicine\(^ {100}\). The Code of Medical Ethics covers issues relating to the character of physician, duties of physicians towards their patients, brotheran practitioners and paramedical profession and to the public. However, the Code does not provide any remedy for aggrieved who is the victim of

\(^{97}\)The Privy Council in the case of Bhandari Vs Advocates Committee,(1956)3 All ER 742 has opined that in every allegation of professional misconduct involving an element of deceit or moral turpitude, it is the duty of the investigating medical council tribunal to apply a high standard of proof and not condemn on a mere balance of probability.

\(^{98}\)See Dr. Harish Bshalla Vs Union of India and others CWP No. 7746/2000, the order dated 04-06-2001.

\(^{99}\)In ancient India , Charaka and Sushruta introduced similar codes.

\(^{100}\)Supra note 92 at page 123.
violation nor enforceable in the court of law. The code governs the relation between the profession and medical practitioners and in no way concern with compensating the patient. Similarly, the Declaration of Helsinki\textsuperscript{101}, the Declaration of Geneva\textsuperscript{102} and the Declaration on the Rights of the patient\textsuperscript{103} which are concerned with rights and duties of physicians and patients are not legally binding any state without being ratification. It is important to note that the Universal Declaration of Human Rights is not a binding legal instrument. It is only a United Nations General Assembly Resolution. Being a world body, the General Assembly could pass only a resolution but not enforce its resolution against any member state without its consent.

1.4. SIGNIFICANCE OF THE STUDY:

The foregoing history of healing act represents that medicine is one of the noble services which has been serving human society since the classical times to the present civilization. In pre-civilization era, the people never saw a doctor as they were treated by the local wise man who was skilled in the use of herbs or by the priest or by the barber who pulled out teeth, set broken bones and performed other operations\textsuperscript{104}. By the sixteenth century where the nomenclature ‘doctor’ came to be used in the healing practice in view of the influx of practitioners possessing medical qualifications from the medical school. With the influence of religious faith, the people believed that “cure comes from God and medicine is just a vessel for God’s will. Every illness of suffering occurs for a reason and is to be accepted as a medium for creation for greater good”\textsuperscript{105}. Therefore, doctors are considered to be the visible gods. They give life to the persons who are suffering with various diseases, injuries, defects etc. Between life and death the medical profession stands tall. Doctors are trustworthy persons\textsuperscript{106}. A person with illness meets a doctor as a ray of hope under the expectation that he is competent and skilled in the art to heal his illness. With this

\textsuperscript{101} The Declaration was originally adopted in June 1964 in Helsinki, Finland, and has since undergone five revisions and two clarifications. It is an important document in the history of research ethics as the first significant effort of the medical community to regulate research itself, and forms the basis of most subsequent documents.

\textsuperscript{102} Adopted in 1948 addresses a physician’s ethical duties especially clinical research.

\textsuperscript{103} Adopted by the 34\textsuperscript{th} World Medical Assembly Lisbon, Portugal 1981 and amended by the 47\textsuperscript{th} General Assembly Bali, Indonesia September 1995.

\textsuperscript{104} www.abdn.ac.uk/english/lion/medicine.shtml visited on 01-11-2008.

\textsuperscript{105} www.maggietron.com/medi/religion.php-17k dated 01-11-2008.

\textsuperscript{106} Indian Bar Review Vol XXX (4) 2003 p 611.
faith that patients approach the doctor and it is at the same time, a duty of the doctor to discharge his obligation with due care and caution.

In India and all over the world, millions of people enter hospitals to undergo treatment for one or other ailment. As patients, their lives are in the hands of doctors and trust them to use their skill, experience and specialization to heal them. Unfortunately, medical professional has become commercialized; the monetary consideration is in reality sole criteria to determine the patient-doctor relationship and the doctors are resorting to unfair practices just to attract the patients like any marketable product and thereby earn money. In addition to these unfair practices, doctors make mistakes and errors even during the time of treatment. Thousands of people are injured every year by surgical errors related to medical negligence and medical malpractice. Medical negligence means failure on the part of the practitioners to exercise the skill, care and prudence that requires preventing a patient suffering injury or illness.

It has been reported that there are approximately 98,000 deaths annually in the United States due to errors during surgery. Surgical errors take place quite often causing serious injury like paralysis or some other permanent disability\(^\text{107}\). The present state of medical malpractice is indeed a national epidemic. In Australia, one in 10 patients’ suffers from medical error and more than 135,000 patients have been affected last year due to medical errors\(^\text{108}\). In Canada as many as 24,000 patients die each year due to medical errors. 87,500 patients admitted to Canadian care hospitals experience an adverse outcome of the treatment. One in 19 adults will potentially be given the wrong medication or wrong medication dosage\(^\text{109}\). More than half a million medical errors have been report in U.K. National Health Service Hospitals\(^\text{110}\). In


\(^{109}\) A report published in the May 25, 2004 edition of the Canadian Medical Association Journal entitles: “The Canadian Adverse Events study; the incidence of adverse events in hospital patients in Canada”. In Canada doctors are defended by a single organization, the Canadian Medical Protection Association, which has 2.9 billion dollars to use this money to hire the best experts and lawyers to defend the case. www.EzineArticles.com/?expert=JohnMckiggan.

\(^{110}\) As cited in Indian Journal of Medical Ethics, Vol.II, No.4, October 2006.
India the extrapolated figures would be 400,000 deaths due to adverse drugs reactions and 720,000 adverse events per annum\textsuperscript{111}.

On the other hand, only small proportion of patients suffering injuries would approach the court for remedy. There are substantial numbers of patients who do not make a claim for damages for injuries suffered as a consequence of medical error or medical malpractice. It was found that out of 7 victims of medical negligence, it is only one patient who files a complaint and when complaints are lodged, the proportion that is successful in obtaining compensation is negligible\textsuperscript{112}. In England, it has been estimated that only 30\% to 40\% of medical negligence cases who successfully obtain compensation\textsuperscript{113}. Although corresponding data is not available in India, the situation here appears to be worse than any other country. Very few patients who have suffered adverse outcomes move the courts and even in that, only a fewer who receives the compensation. In this context, the present work assumes its importance in evaluating the effectiveness of the present tort system and ascertaining causes for medical errors or medical adverse events, why the victims of medical mistakes are unable to approach the court of law for remedies? What are the hurdles to be encountered in the court of law to prove medical negligence? What could be the impact of medical malpractice on the human rights of patients? Whether the existing law ensures bill rights of patients? What could be the effect of medical liability on the part of the medical practitioners? Lastly, how to overcome the fear of doctors in the view of ensuring quality of medical treatment and strengthening the physician and patient relationship? The present work also facilitates for the comprehensive analysis of the relationship between medical practitioners, patients and the society.

1.5. LEGAL DEVELOPMENTS ON THE LAW OF MEDICAL NEGLIGENCE

1.5.1. English Common Law Principles:

The history of development of law on medical negligence is of recent origin in India. It has its foundation in the English common law of \textit{ubi jus ibi remedium}. Indian courts exercise their power to administer law according to ‘justice equity and good conscience’ a principle which indicates that torts are primarily those wrongs for which

\footnotesize{\textsuperscript{111} \url{www.expresshealthcaremgmt.com/20020630/edti2.shtml} accessed on 18-11-2008.  
\textsuperscript{112} Weiler P.C. A Measure of Malpractice, Cambridge Mass, 1993, p.69.  
\textsuperscript{113} Royal Commission on Civil Liability and Compensation for personal injury, Report, Vol I London, 1988.}
either statutory remedies are not available or, if available, are inadequate or inappropriate\textsuperscript{114}. In considering actionable negligence, courts are in fact not only identifying the interests which require protection but also the circumstances under which they need to be protected. The interests of aggrieved are preserved and promoted through the grant of a civil right of action for unliquidated damages. In a tort of medical negligence, the cause of action is personal one that is against the person who has been negligent in discharging his duties and that cause of action does not survive against his estate or the legal representative\textsuperscript{115}. There has been slow growth of tort litigation in India in the area of medical negligence. This is primarily due to lack of awareness about one's own rights, the spirit of tolerance, the expenses involved and the delay in disposal of cases in civil courts owing to overburden of civil dispute litigations.

In September 1984, V. Chandrasekhar, three times national table tennis champion and Arjuna Award winner, admitted to Chennai's Apollo Hospital for treatment of a seemingly innocuous injury. He needed a minisectomy to remove a loose cartilage in his knee, but due to careless during the operation; the oxygen supply was turned off for a few minutes, leading to the death of some brain cells. Mr. Chandrasekhar as a result lost his speech, vision and body coordination and remained unconscious for two months. Even today, because of short vision, he cannot drive; nor can claim the stairs, although his thought process is lucid, there is a gap between thought and speech. Mr. Chandrasekhar demanded compensation but the hospital authorities declined. As a last resort, he sued the hospital, the surgeon and anesthetist in the high court in 1985. The legal battle lasted over 10 years when the Supreme court which awarded Chandrasekhar Rs.19 lakh as compensation in 1995\textsuperscript{116}. If the incidence of medical negligence had taken place 10 later, Chandrasekhar may not have had to wait so long for justice. The Indian law on medical negligence was dormant because the case had to be decided under uncodified rules of tort law or by means of breach of contract under the Indian Contract Act 1972.

\textsuperscript{115} See Balbir Singh Makol vs. Chairman, M/s Sir Gangaram Hospital and others (2001) 1 CPR 49 wherein the rule of action personalis moritur cum persona is recognized.  
1. 5. 2. Consumer Protection Law:

In 1995, in the historical case of Indian Medical Association vs V.P. Shantha\(^{117}\), the Supreme Court of India opened the doors of “consumer court” for victims of medical negligence by bringing medical profession within the scope of a ‘service’ as defined in the Consumer Protection Act 1986. The court held that even though services rendered by medical practitioners are of a personal nature, they cannot be treated as contracts of personal service which are excluded from the purview of the Consumer Protection Act. They are contracts for service, under which a doctor too can be sued in the consumer courts\(^{118}\). The law of medical negligence in India indeed got a new lease of life. However, the law makes a distinction between ‘paid’ health service which falls under the Consumer Protection Act and ‘free’ service which does not. Patients who avail the service in the government hospital free of charge are not consumers, therefore; they cannot invoke the jurisdiction of the consumer court. What happens, if free operation is performed with adverse effects? Is it not violation of human rights? Whether the governmental or charitable hospital entitles to invoke sovereign immunity? The legal remedy may be available in the ordinary civil court of jurisdiction but it is expensive and delays in the dispensation of justice.

1. 5. 3. Recent trends in the applicability of Section 304-A of IPC:

Under section 304-A of Indian Penal Code, a doctor can be punished for causing death by a rash or negligent act during the operation performing upon a patient. A recent judgment of the Supreme Court in Jacob Mathew vs State of Punjab\(^{119}\) holds that the standard of negligence to be proved against a doctor in criminal case of negligence should be so high that can be viewed as ‘gross negligence’, not merely lack necessary care. 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. If the patient dies due to error in judgment or accident, the doctor is not criminally liable. The court expressed its concern that if the criminal liability is extended to the doctor just for the death of the patient due medical error, the consequence would be that the doctors would be worried more about their safety than

\(^{117}\) (1995) 6 SCC 651.


\(^{119}\) 2005 ACJ 1840.
administering treatment to the best their ability. By this observation, it would not be so easy task to prosecute the doctor and get punished under the criminal law of the land; the court however, ultimately came to ‘rescue the doctor’ from criminal liability even if the patient died. Is it practically possible to prove the guilty intention of the doctor in criminal prosecution? How to catch the black sheep in the medical profession? In practice, the Supreme Court virtually extended to the doctors the criminal immunity from the prosecution.

1. 6. IDENTIFICATION AND FORMULATION OF RESEARCH PROBLEMS:

The present work evaluates five inter-related questions on the problem of medical malpractice from the human rights dimension, such as

1. The word ‘right’ connotes variety of meanings. Etymologically, it is derived from the Latin word ‘jus’ which means just, fair, or equity. Whereas, the meaning of Dictionary signifies as the standard of permitted action within a certain sphere. Unless one is clear about the sphere of which he is speaking, however, it is absurd to argue whether a particular act a right or not. Whether a particular action is right, depends upon the general principles on which a system is based. Naturalist argues that rights are those rights which are inherent in every human being by virtue of his personality, while, a positivist defines right as an interest recognized and protected by legal rules. We find different connotations because of ambiguity in the use of the term right. There is need to discuss the genesis and development of the conception of right in the context of jurisprudence, human rights and medical care.

2. Negligence means the omission to do something which a reasonable man would do or doing something which a prudent and reasonable man would not do. This definition neither does indicate the duty of care nor the test to determine a person as reasonable man. Mere negligence in itself does not give a cause of action. To give a cause of action, there must be negligence which amounts to a breach of duty towards the person alleging negligence. In the context of treatment of a patient ‘negligence’ has many manifestations- it may be active negligence, comparative negligence, criminal negligence, gross negligence, willful or reckless negligence etc., There are divergent opinions on what exactly constitutes negligence in the practice of medicine. Therefore,
the present work focuses on identifying the nature and scope of medical negligence.

3. The judiciary plays a significant role in the adjudication of medico-legal cases. Whether the act of the health care provider in question amounts to or does not amount to medical malpractice falls within the province of the court that determines evaluating the reliability of medical expert opinion. However, statutory law does not define the qualifications of medical experts and mandatory guidelines in order to accept their testimony as admissible in establishing negligence. So, it will be necessary to critically evaluate what the practitioners do in fact, how they do and where they err in administering treatment.

4. There are various remedies for medical negligence such as civil remedy, criminal remedy, and administrative remedy. The victim of medical malpractice may approach the Supreme Court or the High Court under article 226 or 32 of the Constitution of India; or invoke the ordinary jurisdiction of civil court/consumer court under the law of torts/contract or the Consumer Protection Act; or the criminal court under the Indian Penal Code. The present study explores challenges posed in the way of securing remedy under the various mechanisms.

5. In 2002, Europe witnessed highest number of medical tourists, India did not figure in the top 10 international tourist destinations because India’s share was just 1.8%. As per research report, approximately 150,000 medical tourists came to India in 2004 and according to the Confederation of Indian Industry; medical tourism in India could become a one billion USD business by 2012. The Indian Government predicts that India’s 17 billion USD a year health care industry could grow 13% in each of the next six years, boosted by medical tourism, which industry watchers say is growing at 30% annually. On the other hand, the public health institutions are unable to compete with the private health care players. There are many issues plaguing the general health care institutions such as lack of infrastructure, non availability of bed accommodation, inadequate measures to maintain sanitation and hygiene, shortage of medical personnel, staff, para -medical staff, reluctance of government doctors to take up the assignment in rural areas etc. To ascertain whether poor patients who approach the public health institutions for treatment
avail of quality of medical service, the empirical study has been undertaken in the research work.

In order to investigate and examine the above research problems, the following questions are required to be analyzed to make them more comprehensive such as,

1. What is the nature and scope of medical negligence?
2. What acts amount to medical negligence and what acts do not amount to medical negligence?
3. What are the remedies available against such medical malpractice?
4. What are the flaws in the professional and self-regulation bodies like medical council?

1.7. REVIEW OF LITERATURE:

Review of literature is one of the important principles of research process which exposes the researcher to the various studies and informations relating to the research area. A thorough study of academic journals, international covenants, conference proceedings, government reports, committees report, books, websites and online literature has been made. So far, some research scholars have undertaken research work on the right to health care, mental health, informed consent, law and medical ethics, law and medicine and medical jurisprudence etc., there is no complete study on “Medical Negligence with Human Rights dimension”. However, there are some studies in this area which does not directly but indirectly relevant to the present study. Some of them are reviewed and discussed herein, such as Medical Negligence in Malasia: Reforming the Law by Dr. Puteri Nemi Jahn Kassim, (2002) International Islamic University, Malaysia; Law of Medical Negligence and Compensation by R.K. Bag which focuses on case law development on medical negligence and remedies available under civil laws, similarly, Law of Medical Negligence and Compensation by Jagajith Singh gives elaborate explanation on medical negligence in India with English case laws. Law and Medical Ethics: Mason, J.K., McCall Smith R.A., and Laurie, G.T., Lexis Nexis Butterworths, London; Medical Negligence Law: Seeking a Balance by Andrew Fulton Philips (1997), Dartmouth Publishing Company Limited., England; Structure and Utilisation of Health Services : An Interstate Analysis by Rama V. Baru, JNU (1994) and so on. However, most of the available literature
belongs to English community perspectives of medical negligence. There is dearth in literature of law of medical negligence with human rights dimension in India. Therefore, the present work attempts to highlight the intricacies involved in the issue of medical negligence with special reference to the empirical study on Mysore district.

Review of literature reveals the following research gaps:

a) The existing law of medical negligence in India does not provide adequate mechanisms to redress the grievances of the victim of medical malpractice.

b) There are constraints on the part of the courts in ascertaining the reliability of the testimony of medical experts, such as accepting the evidence of the medical experts without evaluating, difficulty in securing impartial and honest medical expert etc.,

c) There is lack of humanistic approach in dealing the case of medical malpractice.

d) The Bill of Rights of patients have not been documented yet and given statutory approval.

e) The remedy under the law of contract and the law of tort has become redundant in view of the emergence of Consumer Protection Act.

f) The existing adjudicatory mechanism does not possess the expertization in resolving the issue of medical negligence and there is no ‘health court’ which is competent to try the case of issues relating to the health care.

g) Although the medical care is fundamental in exercising the rights and liberties guaranteed by the Constitution of India, yet the right to medical care is not enforceable against the private health sector in the writ jurisdiction of the Supreme Court and High Courts.

h) The health care providers are not under the mandatory obligation to report to the authorities whenever the medical adverse outcome or medical error takes place in the health care institutions.

1.8. OBJECTIVES OF THE STUDY:

As the research work is based on the analytical and critical evaluation of the existing literature on the medical negligence as a whole and endeavors to establish interface between the cases of medical negligence and their impact upon the human rights of patients, such as the nature of physician-patient relationship, rights and
obligations, principle of informed consent, medical confidentiality, standard of care, remedies as human rights dimension. The work is aimed at enabling the policy makers and implementers to formulate and implement an effective statute that tackles issues of medical malpractice. Judges can take this work as an aid to interpretation and reach at judicial decision. It will help lawyers, doctors, hospital administrators, staffs, patients, medical and law students and lay persons alike in understanding intricacies involved in law and medicine. Besides, the present research contributes towards increasing the existing knowledge of law as well as medicine and suggests reforming the law on medical negligence in India keeping in mind the human rights of subjects of medicine.

1.9. HYPOTHESES:

1. **Social justice to the patient in the present system of tort is a myth.**
   (Although the consumer protection law being viewed as socio-economic oriented law, a patient who avails the service of the government hospital free of charge is not a consumer)

2. **Defending the doctor is easier than establishing the negligence against the doctor.**
   (It is not enough to show that the patient sustained injury as a result of the treatment or mistake of the doctor but the petitioner must prove the alleged act with cogent and reliable medical expert evidence.)

3. **Few medical practitioners are tarnishing the image of the medical profession.**
   (There are many medical practitioners who are not possessed average skill and knowledge to treat the patient and similarly, there are hospitals rendering medical service without possessing required infrastructure and modern medial equipments)

4. **Justice under the equity or humanity is above the justice under the law.**
   (Several litigations of medical mal practice have been dismissed only for the reason that issue of negligence has not been established under the law although indeed the patients have suffered adverse medical outcome.)

5. **For medical service, the doctor and the patient are two faces of the same coin, the protection of the profession leads to the suppression of patient’s rights.** (it is violation of human rights of patients if the health care provider is not held guilty of negligence for lack of care and error of judgment or an accident).
6. Expert evidence is mere opinion and not the conclusive proof. It is wrong to presume the expert evidence as cornerstone of medical negligence cases.

1. 10. SOURCES OF DATA:

So far as collection of data is concerned, there are sources such as direct source and indirect source. The former represents data collected directly from the respondents relating to the factual situation of the health care institutions, quality of medical care, awareness of medical laws dealing with medical profession and human rights of patients etc. The latter comprises primary and secondary data such as national constitutions, legislations, statutory rules and regulations, international charters and conventions, current awareness publications, legal encyclopedias, legal periodicals, websites, textbooks, dictionaries, directories, handbooks sponsored by the public offices and juristic works etc.

1. 11. RESEARCH METHODOLOGY:

The research methodology followed in commissioning the present work covers both empirical and non-empirical methods. For a detailed study of the problem, various international conventions, national constitutions, statutes, textbooks, committee reports, judicial decisions, law and medical journals have been comprehensively analyzed and criticized. The empirical method assumes vital significance as the right to quality of medical treatment has been accepted as a fundamental human right of an individual. This non-doctrinal research focuses on the real problems and difficulties faced by respondents in availing of the medical treatment. Research techniques adopted in undertaking the empirical study are Questionnaire and Interview Schedule. Selection of variables are number of hospitals, number of health centres, number of hospital administrators, number of medical practitioners and number of patients etc.

1. 12. THE SCOPE OF STUDY:

The Constitution ensures everyone’s right to the highest attainable standard of physical and mental health. Article 21 of the Constitution guarantees protection of life and personal liberty to every person. With the adoption of liberal and progressive interpretation, the Supreme Court has observed that the right to live with human dignity has been enshrined in Article 21. As a result, the right to health is integral to
the right to life and the State has a constitutional obligation to provide health facilities. When the government hospital fails to provide a patient timely medical treatment results in violation of the Constitution as well as human rights of patient’s right to life. In a Welfare State, it is the primary obligation of the State to provide health facilities. The Constitutional directives contained in articles such as 38, 39, 42, 47 and 48A address the issues of public health including women and children, such as pure water, food, clothing, shelter, sanitation, cleanliness, surrounding environment or health hazards due to pollution, occupational health hazards, regulation of drugs, blood banks and affordability of medical products, smoking in public places etc. Failure of the State to provide these facilities does not amount to medical negligence. Therefore, in order to attribute negligence or medical malpractice, one must prove the existence of physician and patient relationship between the health care provider and the recipient.

1.13. CONCEPTUAL CLARIFICATION:

1.13.1. Medical Negligence

The simplest way to describe medical negligence is absence of care on the part of a doctor in discharging his duties due to his patient. In other words, breach of duty by a medical practitioner that results in injury to a patient is what is known as “medical negligence” or “medical malpractice” in the terms of American and English laws. It is defined as a medical professional’s “failure to exercise the skill, care, and prudence causing injury to his patient”. It is an improper conduct on the part of any member of the medical profession in discharging his duties for example, failure to attend a patient with due care and caution, refusal to treat a patient in emergency case, failure to extend post-operative treatment, error in conducting pathological test, error of clinical judgment, conducting operation without administering proper anaesthesia or without informed consent, transfusion of mis-matching blood, leaving a foreign object in the patient’s body after operating and administering wrong medicine etc..

1.13.2. Standard of Care

The standards to be applied for determining whether the person charged has been negligence or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled
professional may be possessed of better qualities, but that cannot be made the basis or yardstick for judging the performance of the professional, this proposition is what is popularly called Bolam’s test. Accordingly so long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence.

1.13.3. Medicine-health care, Consumer-service provider and deficiency in service

Though the word “medicine” or “medical” may be used interchangeably with “health” or “healthcare”, both do not bear the same meaning and scope. The medical profession or medical practice is one the dimensions of “healthcare” or “health care delivery”. With the entry of corporate into the health care sector, a patient who avails of medical treatment in the hospital for consideration is termed as a “consumer” or a “recipient” and the hospital is called “service-provider” and treatment (medical or surgery), diagnosis and consultation is a “service”. Any deficiency in medical service may be termed as medical negligence within the meaning of the Consumer Protection Act.

1.14. THE STRUCTURE OF THE THESIS:

The present work is structured in seven chapters, such as

1. General Introduction and Background;
3. Medical Negligence: Nature and Scope;
4. Case law Analysis of Medical Treatment: The Judicial Approach;
5. Remedies for Medical Negligence;
6. Medical Malpractice and Human rights: A Case Study of Mysore District;
7. Conclusion and Suggestions.

Chapter-1 is a “general introduction and background” which deals with the origin and evolution of medicine and hospitals in ancient India as well as ancient world, legal and ethical dimensions of medical practice, the significance of the study with a

120 Bolam Vs Friern Hospital Management Committee, (1957)2 All ER 118.
comparative data on medical errors, the legal developments on the law of medical negligence in India, the identification and formulation of research problems, the review of literature, the research objectives, hypotheses, the sources of data collection, the methodology adopted in this legal research, the scope of the work, conceptual clarification with reference to the meaning of medical negligence, standard of care etc.,

Chapter-2 entitles “the Evolution of the Conception of Rights” focuses on the historical perspectives on the origin and development on the concept of right, human rights and right to health in the national and international sphere. It examines why the people want rights, freedoms or liberties and what for? Can we imagine a world without rights, if not, what does constitute ‘right’? Right is something which emanates from the obligation. However, the celebrated Greek philosophers had the idea of duty rather right, and it is by usage, Latin word ‘jus’ came to be recognized with the concept of ‘right’. For exponents of natural law, the right implies natural right, natural justice and truth but the concept of natural right attracts strong criticisms from the positivist and Marxist. There is no more ambiguous word in legal and juristic literature than the word ‘right’. In the jurisprudential context, rights and duties are necessarily correlative; there can be no right without a corresponding duty or a duty without corresponding right. Similarly, human rights imply correlative duties on the State, as such; everyone has rights against his own State. This chapter also examines philosophical issues, various sources of human rights etc., while dealing with the right to health of individuals. Beside, it explores some issue as to whether the State can plead financial constraints in extending medical service to preserve human life. It was held in the welfare State, it is the constitutional obligation fo the State to provide adequate medical services to all people.

Chapter-3 gives a description of the “nature and scope of medical negligence” with special emphasis on the issue of ‘standard of care’ to be taken by the health care provider in discharging solemn duty of medical care. In common parlance, negligence means carelessness but it cannot be accepted as the precise and appropriate meaning the term negligence because what negligence in common parlance may fall short of negligence at law. In law ‘negligence’ and ‘duty’ exist together, as two faces of the same coin. If a person is charged with negligence, he must owe duty to
another. In the absence of legal duty, there can be no negligence in the legal sense and no legal consequences too, although it may be negligence in the popular sense. There are two rival theories which deal with the nature of negligence, namely the conduct theory and the mental theory. In view of the former, negligence means unreasonably or abnormally dangerous conduct, as such, it immaterial to consider mental shortcoming such as ignorance, stupidity, bad judgment, timidity etc., which produce the mental act. Whereas the later suggests that the state of mind of the actor must be taken into consideration in determining the negligent conduct of the actor. However, both the theories assume importance in ascertaining the liability of the wrong doer. To constitute negligence in law, it must possess three conditions namely,

a) That the defendant owes to the plaintiff a legal ‘duty’ to exercise care;

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

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

But what constitutes medical negligence? Like in ordinary negligence, there are three essential components of negligence:

The existence of duty to take care, which is owed by the doctor to the complainant-patient;

a) The failure to possess that standard of care as prescribed by the law, thereby committing the breach of such duty;

b) Damage, which is both causally connected with such breach and recognized by the law, has been suffered by the complainant.

Every person who enters into the profession, undertakes that he is possessed of a reasonable degree of care and skill to give medical advice and treatment, such a person when is consulted by a patient owes him certain duties, namely

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

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

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

Breach of any of those duties is what is known as “medical negligence” for which the patient gets a right of action for damages or on the basis of which the patient may recover damages from his doctor. It is based upon the existence of duty; as such negligence and duty are correlated to each other. The question of negligence cannot be viewed in isolation of the duty of care. A more appropriate and accepted
definition can be found in the **Bolam’s case** wherein Mc Nair J defined: in the case of a medical man, negligence means “failure to act in accordance with medical standards in vogue which are being practiced by an ordinarily and reasonably competent man practicing the same art”, where there are more perfectly proper standards, if the medical man conforms with any one of those standards, then he is not negligent.

One of the important factors to be considered in assessing breach of duty is “standard of care” which is expected of the doctor. In the above mentioned Bolam’s case it was observed that the test as to whether there has been negligence or not is not the test of man on the top of a Clapham Omnibus, because he has not got this special skill. The test is the standards of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art. Accordingly, a medical practitioner cannot be held negligence for causing injury to his patient unless he falls below the standards of the ordinary skilful and competent member of the medical profession. The present chapter makes critical analysis on the standard of care while explaining general principles, and application of the same principles in specific instances.

**Chapter-4** explores the judicial pronouncement on what may or may not amount to negligence on the part of the health care providers. Accordingly, the chapter is divided into two sub-headings;

a) Acts amounting to negligence and

b) Acts not amounting to negligence.

In Smt. Bhanupal v Dr. Praksh Padode\(^{121}\) the anesthetist administered anesthesia within five hours of examination of the patient, without testing whether the patient had empty stomach or had starved from previous night. The anesthetist did not look into the history which disclosed that the patient was suffering from Asthma. The State Commission held the anesthetist negligence for administering heavy dose of anaesthesia without taking necessary precautions as it was established from evidence that the patient was not properly prepared for anesthesia. In Arunaben D. Kothari v

\(^{121}\) II(2000) CPJ 384 (Bhopal).
Navdeep Clinic\textsuperscript{122} the patient had undergone operation for insertion of plate and screws in his right forearm. The patient developed pain and deformity at the operation site. While examining pathological test the cardiologist did not notice the position of patient as hypertension, yet proceeded with the operation under general anesthesia. The patient developed cardiorespiratory arrest in the midst of the operation and collapsed. The State Commission held the cardiologist negligence for declaring the patient fit for operation without making sufficient diagnosis of condition of heart and cardiovascular system by advising proper investigation and treatment of patient.

In Charan Singh V. Healing Touch Hospital and Others\textsuperscript{123} where the patient who was suffering from stomach ache and burning sensation in passing urine, operated upon by the OP under spinal anesthesia for the removal stone from urethra. It is contended that his right kidney has been removed during the operation without his knowledge. Before carrying surgery for the removal kidney stone, some tests such as culture test, ultra-sound test, kidney function test, x-rays Intravenous polygraphy and other various tests must be carried out but not done and surgery should have been performed under general anesthesia rather than the spinal anesthesia. The issue that arises for the consideration is: whether the failure conduct all tests as claimed by the patient and administer general anesthesia can be termed as negligence of the OP. On perusal of expert evidence and medical literature, it is held by the commission that what test ought to be conducted in a situation and find out the general condition of the patient to ensure whether the patient is to be operated upon under general anesthesia or spinal anesthesia are left to the clinical judgment of the doctors and anesthetist. Where two choices are available, exercise of one, which is the best in the judgment of the doctor unless proved to the contrary does not amount negligence. In Ashok Nandi V. Dr. Ajit Shah and Others\textsuperscript{124} it was held that merely because the operation does not yield desired result, it does not mean the surgeon is negligent. Similarly in Anup Kumar Ghosh V. Dr. T.S. Biswas\textsuperscript{125} the State Commission observed that merely

\textsuperscript{122} 1996(3) CPR 20 (Guj).
\textsuperscript{123} 2003(III) CPJ 62 (NC).
\textsuperscript{124} 2003(II) CPJ 95.
\textsuperscript{125} 1997(II) CPJ 469.
because a doctor could not cure and some other doctor cured the patient on a further treatment does not ipso facto negligence.

**Chapter-5** discusses the remedies available for medical malpractice under various legal provisions in enforcing the liability of health care providers. A victim of medical negligence who intends to sue an erring health care provider has the following options.

a) Compensatory action: seeking monetary compensation before the Supreme Court/High Court or Civil Court of competent jurisdiction or the Consumer Dispute Redressal Forum under the Constitutional Law, Law of Torts/Law of Contract and the Consumer Protection Act respectively.

b) Punitive action: filing a criminal complaint against the doctor under the Indian Penal Code.

c) Disciplinary action: moving the professional bodies like Indian Medical Council/State Medical Council seeking disciplinary action against the health care provider concerned.

d) Recommendatory action: lodging complaint before the National/State Human Rights Commission seeking compensation.

**Chapter-6** deals with empirical studies on medical malpractice and its impacts upon the human rights of patients with special reference to Mysore district, Karnataka. For the purpose of studying the quality of medical care and its affordability to patients and to find out how far facilities in the hospitals are available? What is the physician and patient relationship in reality? Whether the medical practitioners are aware of the medical laws dealing with their profession? Whether the patients are aware of their human rights in relation to medical treatment? Whether the patients are satisfied with the way in which their doctors behave and obviously to ascertain what is the reason for medical negligence? Is it necessary to open patient’s grievance cell to resolve conflict? Can the medical service available in the charitable or public hospital be brought within the ambit of the Consumer Protection Act 1986? The entire Mysore district covering the rural as well as urban areas has been selected. Mysore urban area consist of Mysore city whereas Mysore rural area comprises 7 taluks, such as H.D. Kote, Hunsur, K.R. Nagar, Mysore, Nanjanagud, Periyapatna, T.Narasipura. For
empirical study, a questionnaire was delivered to 200 doctors working in public and private hospitals in Mysore district. Here, each of the respondents has been contacted in person and handed over the questionnaire with a request to provide the relevant data. A sample of 200 doctors was selected using random selection from a list 564 doctors registered with the Indian Medical Association, Mysore Branch and 410 doctors working in Government hospitals in urban and rural areas of Mysore district. In total 100 doctors responded to our questionnaire, a response rate of 50%. Respondents included both graduates and post-graduates (having MD). The questionnaire was followed by in-depth interview of 40 doctors selected randomly from the list of 200 doctors. Likewise, a questionnaire was delivered to 10 government hospitals and 20 private hospitals using random selection from a list furnished by the District and Family Welfare Office. Out of 30 hospitals, 20 hospitals responded to our questionnaire a response rate of 66.6%. In the same way, a questionnaire was delivered to 300 patients who were undergoing treatment in the public and private hospitals on random basis, followed by in-depth interview of 50 patients for extracting information relating to the standard of medical treatment available in the Mysore district. Totally, 180 patients responded to the questionnaire, a response rate of 60%.

The two-types of technique namely personally delivered questionnaire and interview schedule were used to obtain qualitative information on various issues from the respondents. The questionnaire consisted of a set of closed-ended questions and interview schedule was structured in nature in which some of the responses were recorded at the time of interaction to ensure accuracy in the data. However, no significant differences were found between the questionnaire responses and the interview results. Both the questionnaire and interview schedule were considered to draw the findings on the present chapter. The views expressed by the respondents in the questionnaire and during interview were subjective in nature, and efforts were made to corroborate all such views with others and come out with balanced findings. Thus, three sets of questionnaire have been framed for gathering information relating access to medical service, human rights vis-à-vis medical negligence, what prompts a patient to choose a particular hospital for treatment, mode of maintaining medical records, whether the patient furnishes complete information about the facts and circumstances of illness, whether the medical practitioner gets sufficient time to
explain the pros and cons of the treatment, whether the treating doctor/surgeon respects the opinion of the patient in diagnosing the ailment, whether the doctors are aware of human rights of patients and concerned medical laws, and how does the hospital obtain the informed consent of the patients, whether any patient demands the hospital about the accountability and transparency of the medical treatment, whether the hospital has taken insurance coverage for the doctors working therein, whether the hospital meets expenditure from the fee paid by patients and so on.

Chapter-7 consolidates the conclusion from each chapter and makes suggestions for recognizing and enforcing the human rights of patients, strengthening the physician-patient relationship, and protecting the genuine health care providers from unscrupulous patients by foisting false medical malpractice litigation for achieving their personal ends.