CHAPTER - II
CONCEPTUAL STUDY OF
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Matter discussed in this research work with regard to Medical Negligence refer to the tortuous conduct of members of a particular profession which practices Medical Science after being admitted to the profession by the appropriate authorities. The Medical Science today is one of the most developed sciences. It has a long history of its own. For a long time it was beyond the domain of judicial authority. The courts also used to observe hands off attitude. But at present the Medical Profession is subject to judicial review as far as negligent conduct is concerned, and the victims of such a negligent conduct are awarded damages. Before dealing with the specific situations in which the courts have adopted this kind of approach towards the problems of society, it is considered necessary to know something about the Medical Profession itself; how it developed its own rules and regulations in conducting its professional relations with the patients and how at various times various agencies have adopted regulations in regard to the conduct of medical doctors.
This chapter has the object of dealing with matters of medical profession and the concept of medical negligence. The first section of this chapter deals with Medical Profession and the second section deals with the concept of medical negligence falling within the purview of the Law of Torts.

I. The Medical Profession:

In every society, certain work has to be done. Food, clothing and shelter have to be provided; children, the weak, and the old have to be cared for; the sick have to be treated and the dead have to be buried. Children must be educated, gods worshipped and disputes settled. All these jobs have to be divided among the people, but that division can be done in a number of different ways. In all societies, some tasks are prestigious while others have low status; some work is more highly paid than other work, and some jobs are regarded as difficult, dirty or dangerous while others are easy, clean and safe. In Western societies, one aspect of this division of labour has come to be known as a division between professional and non professional occupations.

The major implication of the term profession is that when an occupation calls itself a profession and is accepted as such by law and by the public, it gains a number of advantages. The most significant of these are high status and freedom to control its work. Professions usually also have control over a number of lower status occupations. Hence the term profession is not so much a descriptive term as one which implies value and prestige. People who practice an occupation often try to improve its social status and the push
to become a profession is one way of moving the whole group up in the social hierarchy.¹

In the theories of professionalism, three characteristics are accepted as being essential before an occupation can call itself a profession and thus obtain the considerable increase in prestige that the title gives.

First, professionals must have knowledge in a particular area, and this can only be achieved by years of study followed by examinations which test that knowledge and exclude students who do not reach a required standard;

Second, the training must be broad and generalized rather than narrow and specialized; in particular there has to be a gap between the knowledge and its application to specific cases, so that a profession has to be able to interpret the knowledge that has been learnt.

Thirdly, the professionals must use their judgment in order to do their work.²

These characteristics distinguish professionals from technologists and enable professionally trained people to expand their knowledge throughout their careers. Through the possession of special knowledge professions

¹ Hughes, E. Men and Their Work Glencoe, Ill; Free Press, 1958
² Turner, B.S. ‘Knowledge, Skill and Occupational Strategy: The professionalisation of Paramedical Groups, Community Health Studies, 9, 1, 1985, p. 38
define an area of work as peculiarly their own, and demand the legal right to exclude unqualified people from the practice of the profession. All professions state that they have a service orientation, meaning that their prime aim is to serve their client's interests. To this end they form a professional association which describes their code of ethics, whose aim is usually to regulate the conduct of the relationship between the professional and the client. If the public accepts the profession's claims to specialist knowledge and ethical behaviour, the profession is granted the legal authority and gains the exclusive right to work in this particular field. Its members are licensed to do certain things which others are not permitted to do; they may even claim a mandate to tell society what is appropriate in their field. In this way, for example, doctors are enabled to define health and illness, to prescribe drugs and do surgery, and to define what training is necessary to become a licensed practitioner of their profession.

In the consensus view, the professions perform important social functions. The medical profession, the highest ranking profession in the health field, is regarded as having the vital task of maintaining health and healing illness so that the work of society can go on.

A) Medical science:

For many centuries practitioners of medicine, at least in the Western world, have accepted a moral obligation to serve their patients to the best of their ability and in recent years the medical profession throughout the world
has affirmed this principle repeatedly. Sympathy and the desire to heal and comfort those in physical or mental distress have always characterized the good physician, but worthy motives are not enough. The doctor must have knowledge of people in health and disease, practical skill in dealing with patients and judgment to enable him to use those resources of medicine, which are most appropriate to the needs of each individual. He must, in fact, practice good medicine and today this requires him to have a thorough knowledge of medical science.

Until recent times, two separate elements influenced medical practice. One consisted of ideas about life and death, the structure and function of the body, the nature of disease and the effectiveness of therapeutic procedures. Of these ideas were derived from primitive religion, superstition and magic, but sometimes as in ancient Greece, they resulted from abstract thought of a high order. They contained such beliefs, as that disease was a punishment for sin, the result of evil spells or a derangement of hypothetical humors. Treatment of illnesses, which included purging, starvation, bleeding, the application of leeches and the prescription of alcohol, often did more harm than good.

The second element was observation and description of the patterns of disease and of the results of therapeutic procedures, which had been found by experience to be effective. Two physicians, renowned for their clear descriptions of accurate observations, were the Greek, Hippocrates, who
practiced in the 5th century, B.C. and the 17th century Englishman, Thomas Sydenham. Effective therapeutic measures, developed empirically, included opium for relieving pain, iron for anemia, quinine for malaria, mercury for syphilis, Digitals for heart failure, surgical drainage of abscesses, mechanical reductions of fractures and dislocations and cutting to remove stones from the bladder.

Both these elements are defective. The first suffers from the assumption that ideas do not require validation by experience, the second from a failure to recognize that observation, however extensive does not lead to understanding, unless accompanied by ideas. Nevertheless, both can still be recognized in many quarters today.

Modern western medicine as a whole however is distinguished by being based on science that is on knowledge obtained by observation combined with ideas and reason.

Medical science today comprises a larger body of knowledge derived from the ideas of order, cause and probability, won by the application of scientific method. Medical science is rooted firmly in biological science and draws freely on chemistry, physics, engineering and mathematics. Although it owes much to the study of other animals it concerns ultimately man in health and disease, so that human observation and experiment, rigorously controlled by scientific method are vital to progress. The structure and function of the
body have been clarified to a great extent down to the cellular, molecular and ionic levels. The causes, mechanisms and manifestations of many diseases have been elucidated and clues to the understanding of others are emerging.

Therapeutic measures are not based on the primitive belief that every 'disease' has a cure and every 'poison' an antidote but on the analysis of disease processes and the rational application of measures to prevent, destroy, or augment them respectively, in such a way that they predispose towards causes or the relief of distress. The effective available measures include drugs, surgical operations, radiotherapy, psychotherapy, manipulations, psychotherapy and various other procedures, many of which have been evaluated scientifically and all of which are susceptible to such assessment.

B) Sanctity of life:

The phrases 'sanctity of life' and sacredness of human life have overtones taken from religious terminology and are used to express the presumptive inviolability of the human person, his right to life, with its attendant right to protection in the enjoyment of his total integrity. The principle is found well expressed in the religious texts and the writings of the famous philosophers. The approach adopted by the medical systems of the ancient days and the religions from good old days can be understood from the teachings of the religions and the morals of various cultural entities. This may be described as follows:
C) System of Medicine under various religious traditions and culture:

i) Ancient Hindu System of Medicine:

The medical lore (Ayurveda) of India from ancient until modern times represents the Hindu system of medicine. The traditional texts, attributed to Charaka, Susruta, and Vagbhaa, were settled before about AD 700. They handle certain ethical questions incidentally. Ethics is the proper concern of the Dharmasatra (the science of righteousness). Physicians were required to be dexterous, learned in the precepts of the science of healing from a teacher, tried in practice, and pure. 'Pure' means uncorrupt. They were required to cure, or at any rate to treat, even, the poor and the stranger; but the payment of the fee was recognized as a factor in effecting the cure. Although the physician was to treat the patient honestly, he was under no obligation to treat the terminally sick: on the contrary he should not treat one who is (apparently) incurable, one who is hostile to physicians, or who is the subject or object of enmity on the part of the king.

In return for the physician's acceptance of the duty to treat him, the patient must comport himself obediently, and in general regard the physician as a privileged person like his parent or preceptor, e.g., abstains from dispute with him in any context. The physician must respect totally the confidence of the patient, and it is for this reason that in ancient times spies masqueraded as physicians. There was an exception. Wounds and self-inflicted complaints should be reported to the King, lest the physician be accused of complicity in
crimes. This rule stems from the fact that physicians were licensed by the King, or are at least supposed to have been. In the case of a difficult operation, or treatments hazardous to life, even where the patient gives his consent, a previous notification to the King was recommended, and perhaps even regular, in order to protect the physician. A physician was held, by the Dharmasastra to be immune to suit for damages on the part of a dissatisfied patient, but was liable to a fine for falsely treating him. Incompetence, negligence, and malice were all embraced by the term 'falsely' and the fine would be proportionate to the nature of the offence.

ii) System of Medicine under Islam:

Islamic orthodoxy attempted to build up an Islamic or prophetic medicine on the basis of the Koran and the corpus of sayings ascribed to the Prophet Muhammad (pbuh). Its object was defined as the knowledge of the beginnings of the human body, its condition in health and sickness, the causes and symptoms of the latter, and the means of warding off disease and preserving good health.

If prophetic medicine blurred the rationalistic attitude of the Greek heritage by introducing and sanctifying the use of talismans, potions from the washed off ink of Koran verses and other magical lore, it also helped to defend medicine against opponents from within the ranks of the so-called 'people of the trust in God' and the extreme predestinarians. Prophetic medicine was in fact only one aspect of the Islamic attitude towards medicine.
The other and more brilliant aspect is represented by a multitude of broad-minded Muslim promoters of the healing art among caliphs, scholars and other high-ranking personalities.

The basic ethical text for the Arabic physician regardless of his religion was therefore, the Hippocratic Oath. Other important Greek sources, the influence of which can be traced in the pertinent Arabic literature through the centuries, were Galen's probably spurious commentary on the Oath, his book on "A really good physician—a philosopher" where the physician is warned against being inveigled by worldly goods and pleasures, and the same author's work: On examining the physician which is in fact a guide book for lament instructing them how to assess a good doctor and laying the main stress again on the behavioral side. A good physician should not be a courtier or a lickspittle of rich people. He should not indulge the cravings of his patients as long as any possible damage to their health was involved. And he should watch over the preparation of drugs he prescribed and let nobody interfere with his prescriptions and treatments except responsible and reliable persons. His main concern should not be how to become rich and famous, but how to cure men's illnesses and he should be ready to treat the poor without fees.

These ideals were handed on by Arabic physicians, but relevant writings are few, one of the most important being the book: Adaab Att Tabib or practical ethics of the physician.
iii) Buddhism:

The principles governing Buddhism and the practice of medicine have much in common. The Buddhist Path of Life offers prescriptions for the ethico-spiritual well being of every individual, and the compassion for all creatures without discrimination, which it teaches, is a necessary part of the physicians' attitude towards his patients. Buddhism and medicine are both, in their own ways, concerned with the alleviation, control and ultimate removal of human suffering.

As a result, Buddhism has been closely allied with medicine since its earliest days. The Buddha himself is said to have exercised a ministry of healing and many legends exist of the skills of his personal physician, Jivaka. As early as the time of the Emperor Asoka, who reigned in India in the third century, B.C. hospitals were set up both for humans and animals, and Buddhism inspired the setting up of many institution for the sick in India and Ceylon and subsequently in other Southeast Asian countries.

Buddhism devotes itself to the purification of the mind—to mental culture—as the predominant means of attaining the state of Supreme Enlightenment, the ultimate goal of man. It seeks to enable persons to meet both present and changing circumstances with serenity of mind.

The approach of Buddhism to medicine is therefore very much along psychosomatic lines, although the socio-economic condition of people is not
ignored, since this needs to be right and wholesome if the behaviour of the individual is to be correct. "Mind is the forerunner of all evil and good conditions; it is the chief; mind-made are all things."

It is not suggested, however, the physical disease does not exist. Disease and suffering are a part of the life of all men until suffering is eventually eliminated when Supreme Deliverance is achieved. The Buddhist emphasis on medical care derives from the fact that physical health is a necessary basis for mental culture, and the medical profession has an important part to play in curing physical diseases in order that the mind may develop.

All Buddhists are expected to take reasonable care of their own health, since disease and the resulting mental suffering are a hindrance to the march towards enlightenment. This correlation between bodily health and the higher life adds a spiritual dimension to medical ethics through the ideal of selfless service.

iv) Christianity:

In its origins Christianity shared with Judaism, and with most of the ancient world, a sense of the close relationship between religion and medicine. Salvation and healing, though not identical, were seen as different aspects of the same divine activity. Thus, a cure for leprosy must have its ritual expression and unforgiving sin might lie at the root of paralysis. Jesus
told his followers to preach the gospel and heal the sick, and in his own ministry did both in such a way that the one illuminated and exemplified the other. Ethical problems, like whether or not it was permissible to heal on the Sabbath presupposed that healing was not an end in itself, but must be understood in the larger context of the religious meaning of life.

Though the emphasis on direct miraculous healing faded soon after the end of the New Testament period, Christianity never lost its broad concern with health. Care for the sick was institutionalized from the 4th century A.D. onwards in the development of Christian hospitals almost invariably based on monastic foundations. Early scientific medicine, in the tradition of Hippocrates and Galen was absorbed into medieval Christendom together with many other aspects of Greco Roman culture. But while the religious framework of life provided a support and justification for medicine, it also tended to inhibit discovery and innovation. The growth of more modern medicine from the 17th century onwards demanded a sharp assertion of autonomy over against its former religious associations, and for a time there was widespread Christian opposition to new medical techniques. Anesthesia, narcotics in childbirth, vaccination, contraception, sterilization and many other procedures have all been condemned by influential Christian bodies, and some still are. In more recent years, however there has been a greater readiness from both sides to engage in rational and open discussion of the ethical implications of various kinds of scientific advance and claims to strict autonomy, whether scientific, medical or religious, are being modified.
D) The Organization of Medical Profession:

In England, the medical profession has by now organized itself, first through its own associations, and then through chartered bodies like the Royal Colleges. Legislation enacted by the Parliament of England on medical education and medical profession has streamlined the system as far as registration of medical practitioners is concerned. The professional bodies have been conferred powers to regulate the functioning of medical institutions. These bodies are charged with the responsibility of taking action against practitioners whose conduct does not conform to the standard set by these professional bodies.

Likewise, in India also the Medical profession is a well-organized profession. There is a parliamentary legislation regarding medical education and medical profession. A professional body regulates the registration and functioning of the medical practitioners and monitors the functioning of various medical institutions. This body is charged with the responsibility of taking a doctor to task if his conduct does not conform to the standard set by the professional body.

Apart from the method of dealing with the disciplinary cases of doctors within the system of medical profession, there is the rule of accountability working on a higher plane, and that is through the instrumentality of the courts of law. In the beginning, the courts of civil jurisdiction dealt with the complaints against the doctors, but now more than one jurisdiction is available to lodge a
complaint with the judicial bodies. There is the court of civil jurisdiction, the modern forum of Consumer Redressal agencies, and the courts of Writ jurisdiction. These several jurisdictions are open to the aggrieved persons to approach and seek a remedy against the conduct of the medical practitioner. Each jurisdiction is open depending upon the nature of the claim and the nature of the cause of action. As far as Medical Negligence is concerned, the jurisdiction available to an aggrieved person is the civil jurisdiction. Then there is the consumer redressal forum and the courts of higher jurisdiction. The cases dealt with by these redressal agencies have been dealt with in the subsequent chapter.

Not only that the rules and regulations come to our doctors from the local legislatures and the local administrative agencies, there are certain regulations framed by the foreign agencies also which are relevant to the subject of medical discipline. The following are the important Declarations to which a reference is necessary at this stage to show how the medical profession has come to be regulated by rules formulated by more than one agency. These regulations pertain to more than one aspect of the conduct of medical practitioners, and that too in regard to more than one matter.

E) Declarations adopted by International Organizations in regard to the Conduct of Doctors in various situations:
i. The Nuremberg code (1947):

On August 19, 1947, a War Crimes tribunal at Nuremberg rendered judgment on 23 German defendants, mostly physicians, who were accused of crimes involving experiments on human subjects. The judgment laid down ten standards to which physicians must conform when carrying out experiments on human subjects as follows:

1. Permissible medical experiments: The great weight of the evidence before us to the effect that certain types of medical experiments on human beings, when kept within reasonably well defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods of means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts.

2. The voluntary consent of the human subject is absolutely essential: This means that the person involved should have legal capacity to give consent; it be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching or other ulterior form of constraint or coercion; and should have sufficient knowledge and constraint or coercion, and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This
latter element requires that before the acceptance of an affirmative
decision by the experimental subject there should be made known to
him the nature, duration, and purpose of the experiment; the method
and means by which it is to be conducted; all inconveniences and
hazards reasonably to be expected, and the effects upon his health or
person which may possible come from his participation in the
experiment.

3. The experiment should be such as to yield fruitful results for the
good of society, unprocurable by other methods or means of study, and
not random and unnecessary in nature.

4. The experiment should be so designed and based on the results of
animal experimentation and knowledge of the natural history of the
disease or other problem under study that the anticipated results justify
the performance of the experiment.

5. The experiment should be so conducted as to avoid all unnecessary
physical and mental suffering and injury.

6. No experiment should be conducted where there is any prior reason
to believe that death or disabling injury will occur; except, perhaps, in
those experiments where the experimental physicians also serve as
subjects.
7. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

8. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death.

9. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

10. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental stage where continuation of the experiment seems to him to be impossible.

During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill, and careful
iii. Declaration of Geneva (1949; Amended, 1968):

At the time of being admitted as a member of the medical profession:

1) I will solemnly pledge myself to consecrate my life to the service of humanity;
2) I will give to my teachers the respect and gratitude which is their due;
3) I will practice my profession with conscience and dignity;
4) The health of my patient will be my first consideration;
5) I will maintain by all the means in my power the honor and the noble traditions of the medical profession;
6) My colleagues will be my brothers;
7) I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;
8) I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

iii. Declaration of Helsinki (1964):

Recommendations guiding Medical Doctors in Biomedical Research involving Human subjects; Basic Principles:

1. Biomedical research involving human subjects must conform to generally accepted scientific principles and should be based on adequately performed laboratory and animal experimentation and on a thorough knowledge of the scientific tradition.

2. The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experiment protocol, which should be transmitted to a specially appointed independent committee for consideration, comment and guidance.

3. Biomedical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of the research, even though the subject has given his or her consent.

4. Biomedical research involving human subjects cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

5. Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison
with foreseeable benefits to the subjects or to others. Concern for the interests of the subject must always prevail over the interest of science and society.

6. The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to minimize the impact of the study on the subject's physical and mental integrity and on the personality of the subject.

7. Doctors should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Doctors should cease any investigation if the hazards are found to outweigh the potential benefits.

8. In publication of the results of his or her research, the doctor is obliged to preserve the accuracy of the results. Reports of experimentation not in accordance with the principles laid down in this Declaration should not be accepted for publication;

9. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from
participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The doctor should then obtain the subject's freely given informed consent, preferably in writing.

10. When obtaining informed consent for the research project the doctor should be particularly cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a doctor who is not engaged in the investigation and who is completely independent of this official relationship.

11. In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation. Where physical or mental incapacity makes it impossible to obtain informed consent, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with national legislation.

12. The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present Declaration are complied with.

iv. Declaration of Sydney (1968):

A statement on death:
The determination to the time of death is in most countries the legal responsibility of the physician and should remain so. Usually, he will be able without special assistance to decide that a person is dead, employing the classical criteria known to all physicians.

Two modern practices in medicine, however, have made it necessary to study the question of the time of death further:

(1) The ability to maintain by artificial means the circulation of oxygenated blood through tissues of the body which may have been irreversibly injured, and

(2) The use of cadaver organs such as heart or kidneys for transplantation.


Statement on Therapeutic Abortion:

1. The first moral principle imposed upon the doctor is respect for human life as expressed in a clause of the Declaration of Geneva: I will maintain the utmost respect for human life from the time of conception.

2. Circumstances which bring the vital interests of a mother into conflict with the vital interests of her unborn child create a dilemma and raise the question whether or not the pregnancy should be deliberately terminated.
3. Diversity of response to this situation results from the diversity of attitudes towards the life of the unborn child. This is a matter of individual conviction and conscience which must be respected.

4. It is not the role of the medical profession to determine the attitudes and rules of any particular state or community in this matter, but it is our duty to attempt both to ensure the protection of our patients and to safeguard the rights of the doctor within society.

5. It is not the role of the medical profession to determine the attitudes and rules of any particular state or community in this matter, but it is our duty to attempt both to ensure the protection of our patients and to safeguard the rights of the doctor within society.

6. Therefore, where the law allows therapeutic abortion to be performed, or legislation to that effect is contemplated, and this is not against the policy of the national medical association, and where the legislature desires or will accept the guidance of the medical profession, the following principles are approved:

   (a) Abortion should be performed only as a therapeutic measure;

   (b) A decision to terminate pregnancy should normally be approved in writing by at least two doctors chosen for their professional competence;
(c) The procedure should be performed by a doctor competent to do so in premises approved by the appropriate authority.

vi. Declaration of Tokyo (1975):

Statement on torture and other cruel inhuman or degrading treatment or punishment:

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The
doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall, prevail against this higher purpose.


Ever since the dawn of culture, ethics has been an essential part of the healing art. Conflicting loyalties for physicians in contemporary society, the delicate nature of the therapist-patient relationship, and the possibility of abuses of psychiatric concepts, knowledge and technology in actions contrary to the laws of humanity all make high ethical standards more necessary than ever for those practicing the art and science of psychiatry.

As a practitioner of medicine and a member of society, the psychiatrist has to consider the ethical implications specific to psychiatry as well as the ethical demands on all physicians and the social duties of every man and women.

A keen conscience and personal judgment is essential for ethical behaviour. Nevertheless, to clarify the profession's ethical implications and to guide individual psychiatrists and help form their consciences, written rules are needed.
Therefore the General Assembly of the World Psychiatric Association has laid down the following ethical guidelines for psychiatrists all over the world:

1. The aim of psychiatry is to promote health and personal autonomy and growth. To the best of his or her ability, consistent with accepted scientific and ethical principles, the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of health resources. To fulfill these aims it requires continuous research and the continual education of healthcare personnel, patients and the public.

2. Every patient must be offered the best therapy available and be treated with the solicitude and respect due to the dignity of all human beings and to their autonomy over their own lives and health. The psychiatrist is responsible for treatment given by the staff members and owes them qualified supervision and education. Whenever there is a need, or whenever a reasonable request is forthcoming from the patient, the psychiatrist should seek the help or the opinion of a more experienced colleague.

3. A therapeutic relationship between patient and psychiatrist is founded on mutual agreement. It requires trust, confidentiality, openness, co-operation, and mutual responsibility. Such a relationship may not be possible to establish with some severely ill patients. In that
case, as in the treatment of children, contact should be established with a person close to the patient and acceptable to him or her. If and when a relationship is established for purposes other than therapeutic, such as in forensic psychiatry, its nature must be thoroughly explained to the person concerned.

viii. Medical Council of India Declaration:

At the time of registration, each applicant is to be given a copy of the following declaration by the Registrar concerned, and shall read and agree to abide by the same:

- "I solemnly pledge myself to consecrate my life to the service of humanity.
- Even under threat, I will not use my medical knowledge contrary to the laws of humanity.
- I will maintain the utmost respect for human life from the time of conception.
- I will not permit consideration of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.
- I will practice my profession with conscience and dignity.
- The health of my patient will be my first consideration.
- I will respect the secrets which are confided in me.
- I will give to my teachers the respect and gratitude which is their due.
• I will maintain, by all means in my power, the honour and noble traditions of medical profession.
• My colleagues will be my brothers.
• I make these promises solemnly, freely and upon my honour."

a) General Principles:

The prime object of the medical profession is to render service to humanity; reward of financial gain is a subordinate consideration. Whosoever chooses this profession, assumes the obligation to conduct him in accord with its ideals. A physician should be an upright man, instructed in the "art of healings." He must keep himself pure in character and be diligent in caring for the sick. He should be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life.

b) Duties of Physicians to their patients:

Obligations to the sick: Though a physician is not bound to treat each and every one asking his services except in emergencies for the sake of humanity and the noble traditions of the profession, he should not only be ever ready to respond to the calls of the sick and the injured, but should be mindful of the high character of his mission and the responsibility he incurs in the discharge of his professional duties. In his ministrations, he should never forget that the health and the lives of those entrusted to his care depend on
his skill and attention. A physician should endeavor to add to the comfort of
the sick by making his visits at the hour indicated to the patients.

Patience, delicacy and secrecy: Patience and delicacy should
classify the physicians. Confidences concerning individual or domestic
life entrusted by patients to a physician and defects in the disposition or
caracter of patients, observed during medical attendance should never be
revealed unless their revelation is required by the laws of the State.
Sometimes, however, a physician must determine whether his duty to society
requires him to employ knowledge, obtained through confidences to him as a
physician, to protect a healthy person against a communicable disease to
which he is about to be exposed. In such instance, the physician should act
as he would desire another to act towards one of his own family in like
circumstances.

Prognosis: The physician should neither exaggerate nor minimize the
gravity of a patient's condition. He should assure himself that the patient, his
relatives or his responsible friends have such knowledge of the patient’s
condition as will serve the best interests of the patient and the family.

The patient must not be neglected: A physician is free to choose whom
he will serve. He should, however, respond to any request for his assistance
in an emergency or whenever temperate public opinion expects the service.
Once having undertaken a case, the physician should not neglect the patient,
nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdraw to allow them to secure another medical attendant. No provisionally or fully registered medical practitioner shall willfully commit an act of negligence that may deprive his patient or patients from necessary medical care.

c) Disciplinary Action:

The Medical Council of India desires to bring to the notice of the registered medical practitioners the following statement upon offences and forms of professional misconduct which may be brought before the appropriate Medical Council for disciplinary action in view of the authority conferred upon the Medical Council of India and / or State Medical Councils, as provided under Indian Medical Council Act 1956, or State Medical Council Acts, as may be subsequently amended.

The appropriate Medical Council may award such punishment, as deemed necessary. It may direct the removal altogether (professional death sentence) or for a specified period (penal erasure), from the Register the name of any registered practitioner, who has been convicted of any such offence as implies in the opinion of the Medical Council of India and / or State Medical Councils, a defect of character, or who, after an enquiry, at which opportunity has been given to such registered practitioner to be heard in person or by pleader, has been held by the appropriate Medical Council to
have been guilty of serious professional misconduct. The appropriate Medical Council may also direct that any name so removed shall be restored.

It must be clearly understood that the instances of offences of professional misconduct which are given do not constitute and are not intended to constitute, a complete list of the infamous acts, which may be punished by erasure from the Register, and that by issuing this notice the Medical Council of India and/or State Medical Councils are in no way precluded from considering and dealing with any form of professional misconduct on the part of a registered practitioner. Circumstances may and do arise from time to time in relation to which there may occur questions of professional misconduct which do not come within any of these categories. Every care should be taken that the code is not violated in letter or spirit. In such instances, as in all others, the Medical Council of Indian and/or State Medical Councils have to consider and decide upon the facts brought before the Medical Council of India and or State Medical Council.

A medical practitioner is entitled to appeal to the Central Health Ministry against the decision of the Medical Councils.

II. (A) Concept of medical negligence in the sphere of tortuous liability:

A tort is a civil wrong which entitles a person who is injured by its commission to claim damages for his loss, whether purely by way of
reparation or as a way of bringing home to the defendant the anti-social nature of his act.

A breach of a contract is, like a tort, a civil wrong, but it is different from tort. Whereas contractual duties are imposed by the parties to the contract themselves, the duty to refrain from committing torts is imposed by the general law of the land independently of the wishes of the plaintiff or the defendant.

Tortuous liability (liability in tort) arises from the breach of duty primarily fixed by law. It is a duty toward persons generally and its breach is redressible by an action for unliquidated damages.

The law of tort is therefore concerned with the allocation or redistribution of those losses which are bound to occur in society. In any society, there are numerous conflicts of interests and the actions of one man or group of men will from time to time cause damage to others. This damage may take many forms, e.g. physical injury to the person (assault or battery), physical damage to property, and damage to financial interests, or injury to one's reputation.

The law gives redress or remedy to those who so suffer. It is the function of the Law of Tort to determine when it will or will not grant redress for the damage suffered. An action in tort is an action between persons – natural or artificial. The person who is liable is the person who committed the
wrong. However, there is vicarious liability where one person may be liable for the acts of another—usually agents, servants, employee and even independent contractors.

II. (B) Characteristics of Tortuous Liability:

The chief source of the law of torts is the Common Law i.e. decided cases. Then there are the statutes enacted by the appropriate legislatures. According to the rules embodied in these laws there are three forms of liability.

1) Strict Liability:

This is liability which does not require intention or negligence. Once you commit the tort whether you were negligent or not, whether you intended the result or not, you will be liable. This is known as the Rule in *Rylands and Fletcher* where it was said...

"If a person brings or accumulates on his land anything which, if it should escape, may cause damage to his neighbor, he does so at his peril, if it does escape, and cause damage he is responsible, however, careful he may have been, and whatever precautions he may have taken to prevent the damage."

The facts of the case were that the defendant desired to construct a reservoir upon his land. He employed an independent contractor to execute the work. Unknown to the defendant there was a disused shaft of a coal mine
under the proposed site of the reservoir, which communicated with and adjoining mine belonging to the plaintiff. Through the contractor's negligence, this shaft was not discovered. As a consequence, when the reservoir was filled, the plaintiff's mine was flooded and he suffered damage. It was held that, despite the defendant's innocence, the plaintiff would succeed.

2) Liability Based on the Fault:

This kind of liability requires either intention or negligence. Usually in tort, a party is considered to intend that which is the necessary or natural consequence if his act, e.g., where one shoots in order to scare a dog but actually kills it, intention signifies the defendant's advertence to his conduct and to its consequence plus the desire for those consequences. Negligence signifies total or partial inadvertence of the defendant to his conduct and/or its consequences.

3) Liability where no actual damage need to be proved:

In normal torts in order to win and be awarded damages, one must prove that he has suffered damages. Torts which do not require proof of damages are trespass and libel.

Motive and malice are not essential in the law of tort except in a few instances e.g. malicious prosecution and defamation. Motive could be described as the reason for conduct. Malice signifies the doing of an act willfully without a just cause or excuse – e.g. malicious prosecution.
Therefore malice is evil motive or intention. This is illustrated by the case of Bradford Corporation and Pickles. Pickles wished to sell his land to the corporation. This piece of land was situated in between his land and the corporation land. The corporation refused to purchase the land. Pickles was annoyed. Therefore he decided to sink a deep shaft in his land thereby diminishing the amount and quality of water in the Corporation's land on the lower part. On an action by the corporation, Pickles was held not liable because motive is immaterial. It was observed:

"This is not a case in which the state of mind of the person doing the act can affect the right to do it. If it was a lawful act, however ill the motive might be, he had a right to do it. If it was an unlawful act, however good his motive might be, he would have no right to do it. Motives and intentions in such a question as is now before your lordships seem to me to be absolutely irrelevant."

4) Vicarious liability:

Hospitals are corporations, and therefore being artificial persons, they can only act through the agency of others. They have a legal personality as they are a legal entity. They can sue and be sued. Therefore the general rule of law imposes liability upon a master for torts committed by his servant acting in the course of his employment. But the true basis of the vicarious liability of a master for his servant's torts is not any wrong doing or wrongful command of the master – but simply it is founded upon the principle of public policy.
requiring the master, who obtains the benefit of his servant to hold the rest of
the world harmless from his activities. Hence no logical difficulty need prevent
a statutory corporation from being liable to compensate persons injured by its
servants while acting in the course of their employment; indeed so far have
the requirements been pushed that it has been held that a statutory
corporation may be made liable in damages for the torts committed by its
servants when engaged in an undertaking which is ultra-vires to the
corporation.

5) Liability in the Relation of Master and Servant:

The circumstances that give rise to the relation of master and servant
for this purpose are: If the defendant (Corporation) had the legal power to
control the mode in which the services were performed by the actual tort, then
the relation exists and the defendant is liable if the tort was committed in the
course of employment.

For instance a local authority undertaking the running of buses has this
legal power of controlling the mode in which its drivers perform their work and
is therefore liable for injuries caused by the negligent driving of one of its
buses. It was formerly thought that professional men employed to undertake
work in which their technical skill was to be exercised could not have been
engaged on the terms that their employer should be able to control the way in
which they performed their functions, and hence were not in law their
servants; this problem arose in respect of hospitals. It is now settled that a
hospital authority, by receiving patients, comes under a duty of care to them which extends to require it to provide competent staff, including the necessary professional qualified staff.

On the other hand, where a patient uses the hospital as a place in which he may be treated by his own listing physician or surgeon, the hospital authority is not vicariously liable for the latter's acts. So the hospital authority is liable for the negligence of a resident medical officer, and for the nurses employed by it, save in so far as they are acting without negligence on their part under immediate directions of physicians who are not themselves the servants of the hospital authority.

Similarly a hospital authority is under a duty to see that its premises are safe for the reception of patients, and failure to perform this duty, though resulting from an omission of the professional staff to take proper precautions will render the authority liable.

6) The Concept of Employer's Liability as applied to Hospitals:

An employer has a duty:

(a) To provide reasonably safe premises

(b) To provide safe equipment, tools and work materials

(c) To provide a safe system of work
Duties of an Occupier of Premises:

The occupier of premises will be liable on the ordinary principles to anyone who happens to suffer harm because he (the occupier) has been negligent in carrying on any activity in the premises.

Where persons are present in the premises under a normal contract, then duties created by the terms of the contract itself will create similar duties to the occupier. If no such terms exist, then implied terms will create those duties.

In respect of trespassers no duties exist. Trespassers should take the premises as they find them and the occupier is under no duty to make his premises safe for trespassers. But he should not lay traps in order to harm them.

An occupier of premises owes the common duty of care to all visitors. The common duty of care is a duty to take such care as in all the circumstances of the case is reasonable to see that the visitor will be reasonable safe in using the premises for the purposes for which he is invited or permitted by the occupier to be there.

But the occupier must appreciate the fact that children are less careful than adults and therefore more care should be exercised. And finally, a
person in exercising his vocational calling must appreciate and guard against any special risks ordinarily incidental to his calling.

The hospital will be held responsible to see to it that all those who are lawfully there, are safe. If one suffers damage because the hospital has not taken such care, then the hospital will be held responsible.

7) The Specific Tort for which the Liability arises:

a. The tort of nuisance:

Nuisance is generally described as harm. It is an annoyance to another person, which is unlawful. Eminent writers rarely define the word nuisance. At best they categorize it as a private or public nuisance.

I. Public Nuisance:

Public Nuisance is a crime. It includes things like obstructing highways or making them dangerous for use. It means therefore a private citizen cannot sue another for public nuisance unless he can show that he suffered special damages which the general public did not suffer.

II. Private Nuisance:

Private Nuisance is not a crime but a tort. It is a wrong which interferes with the enjoyment of some right to land, short of being a trespass, e.g. by noise, smoke etc. it is not a direct interference with land. Overhanging branches of a tree can be a nuisance. Obstructing the passage of light into one's house is a nuisance as was said in Fleming and Hislop.
"What causes material discomfort and annoyance for the ordinary purposes of life to a man’s house or to his property, is to be restrained although the evidence does not go to the length of proving that health is in danger."

But it must be understood that this is an arbitrary standard which cannot be set up which is applicable to all localities. There is a local standard applicable in each particular district, but, though the local standard may be higher in some districts than in others, yet the question in each case ultimately reduces itself to the fact of nuisance or no nuisance, having regard to all the surrounding circumstance.

In Colls and Home and Colonial Stores Limited it was stated as follows: "A dweller in town cannot expect to have as pure air, as free from smoke, smell and noise as if he lived in the country, and distant from other dwellings, and yet an excess of smoke, smell and noise may give cause of action, but in each of such cases it becomes a question of degree."

One cannot operate a tuberculosis patient in a residential area. It does not matter whether or not the existence of that patient constitutes a real danger to the people in the vicinity. The question is, not whether the fear of the people is founded in science, but whether it exists. That fear could be imaginary but if it is real in that people feel uncomfortable, an injunction may be issued.
Salmond on Torts summarizes what he calls "Ineffectual Defences" as follows:

(1) It is no defence that the plaintiffs themselves came to the nuisance.
(2) It is no defence that the nuisance although injurious to the plaintiffs is beneficial to the public at large.
(3) It is defence that the place from which the nuisance proceeds is a suitable one for carrying on the operation complained of, and that no other place is available in which less mischief would result.
(4) It is defence that all possible care and skill are being used to prevent the operation complained of from amounting to a nuisance.

Nuisance is not a Branch of the law of negligence.
(5) It is defence that the act of the defendant would not amount to a nuisance unless other persons acting independently of him did the same thing at the same time.
(6) He who causes a nuisance cannot avail himself of the defence that he is merely making a reasonable use of his own property. No use of property is reasonable which causes substantial discomfort to others or is a source of damage to their property.

Having said all this, it must be remarked that people who are abnormally sensitive or who possess property which is abnormally liable to damage, should not be heard to complain of nuisance. If they have exceptional sensitivity, then they must put up with the inconveniences. In Robinson and Kilvert. The plaintiff complained that defendant, heating his
adjoining flat in the ordinary way, caused injury to his sensitive paper industry. The paper was brown and was abnormally sensitive to heat which ordinary paper would not have suffered any damage. The activities of the defendant did not constitute nuisance and therefore the plaintiff failed.

It’s Relationship to Hospitals:

A hospital may be liable for nuisance, if it is situated near a residential area so that noises disturb the residents.

b. The Tort of Trespass:

The relevant aspect of trespass as far as hospitals are concerned is battery. Battery has been defined as an intentional physical interference with the person of another, however slight, in a hostile manner or against his will. If this is true, follows that a doctor does not have an automatic right to physically examine or treat someone. If he does so without the patient’s consent, this will amount to trespass to the person.

c. The tort of defamation and breach of professional confidence:

(1) The wrong of defamation consists in the publication of a defamatory statement in respect of another person without lawful justification. A defamatory statement is not necessarily made in words it is either written or spoken. A man may defame another by his acts. The exhibit of an insulting picture holding up the plaintiff to ridicule or contempt is
an actionable libel. So also is the act of placing an effigy of the plaintiff among those of murderers and other ill-famed persons in an exhibition.

(2) The wrong of defamation is of two kinds – namely libel and slander. In libel, the defamatory statement is made in some permanent and visible form, such as writing, printing, pictures or effigies. In slander it is made in spoken words or in some other transitory form whether visible or audible, such as gestures, kissing or other inarticulate but significant sounds.

(3) Libel is not merely in actionable tort, but is also a criminal offence, whereas slander is a civil injury only. Libel is in all cases actionable only on proof of actual damage.

(4) A defamatory statement is one which has a tendency to injure the reputation of the person to whom it refers, which tends to diminish the good opinion that other persons have of him and to cause him to be regarded with feelings of hatred, contempt, ridicule or fear. Mere insult does not amount for defamation if it does not consist of a false statement (calling someone “dog” is different from calling a person “prostitute”).

The test of defamatory nature of a statement is its tendency to excite against the plaintiff the adverse opinions or feeling of other persons.
For example, to say one is a fraudulent business man / a woman is a prostitute, a person is insane even if true, a trader is insolvent.

It is essential in every action for defamation that the defamatory statement should be shown to refer to the plaintiff not necessarily express. It could be latent.

It is not necessary that the defendant should have intended the defamatory statement to refer to the plaintiff. The question to be determined is whether any person to whom the statement was published reasonably thought that the plaintiff was the person referred to.

A man publishes defamatory statements at his peril. Defamation can also be made of a class of people. For example express reference to a sect of priests generally.

**Innuendo:**

An allegation which on the face of it contains no imputation whatever against the plaintiff but may be proved from the circumstances to have contained a latent and secondary defamatory sense. The plaintiff must expressly and explicitly set forth in his pleadings the defamatory sense which he attributes to it. This is hidden defamation.
There must be publication to a person other than the plaintiff himself. For example, if written allowing another person to read. Direct handing of an insulting letter to plaintiff is not defamation even if he himself shows it to other person.

**Slander:**

These are spoken words for which one must prove special damage. But others may be actionable per se, i.e. without proof of special damages:

a) An imputation that the plaintiff has committed a criminal offence.

b) An imputation that the plaintiff suffers from an existing contagious venereal disease.

c) An imputation of unchastity against a woman.

d) An imputation against the plaintiff by way of his business/office.

"Words spoken and published which impute unchastity or adultery to any woman or girl shall not require special damage to render them actionable."

**III. The Concept of Medical Negligence:**

The question to be considered is what standard of skill that a Doctor is expected to have in the diagnosis and treatment of patients and the due care and attention that is required of him failing which the Doctor can be said to be
negligent. The matter is not free from difficulties. In strict legal analysis "negligence" means more than careless conduct. It connotes:

(1) Duty to take care,
(2) Breach of the duty and
(3) Damages thereby suffered by the person to whom the duty owed.

Such a duty may arise from a contract but it can arise independently out of a contract also. That duty of care arising independently out of contract is based upon the fact that the Doctor has undertaken the treatment of the patient. The test is standard of an ordinary skilled man exercising and professing to have special skill. It is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man practicing that particular profession.

In *A.S. Mittal v. State of Uttar Pradesh* their Lordships of the Supreme Court said,

"The skill of medical practitioner differs from doctor to doctor. The very nature of the profession is such that there may be more than one course of treatment, which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of this ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is

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4 AIR 1989 SC 1570 = JT 1989 (2) SC 419
acceptable to the medical profession and the Court finds that he has attended on the patient with due care, skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence."

Where the doctors act carelessly and in a manner, which is not expected of a medical practitioner, then an action in tort would be maintainable.

In Rogers v. Whitaker\textsuperscript{5}, where doctor’s negligence was discussed it was observed:

"The question is not whether the doctor's conduct accords with the practice of medical profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the Court to decide and the duty of deciding it cannot be delegated to any profession or group in the community."

A definition of negligence universally acknowledged to be the best is a common sense one. It was given by Baron Alderson (Blyth v. Birmingham Waterworks Company; Bridges vs. Directors, etc of NL Railway; Governor General in Council vs. Mt. Saliman)\textsuperscript{6}, "Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something

\textsuperscript{5} (1993) 109 ALR
\textsuperscript{6} 1856 II Ex.781; 1873-74 LR 7 HR 213; 1948 ILR 27 Pat.207
which a prudent and reasonable man would not do..." Applied to a medical man and borrowing the language of Baron Alderson, a definition of medical negligence may be stated thus: Negligence on the part of a medical man is the omission to do something which a reasonably competent medical man, guided by such medical knowledge and practice as is commonly known at the time and place where he practices, and further guided by such other considerations which ordinarily regulate the conduct of reasonably competent medical man, would do, or doing something which a reasonably competent medical man would not do.

Negligence may arise by doing something as well as by omitting to do something. Once a medical man takes a case in hand he will be answerable as much for wrong advice or treatment given as for failing to give the right advice or treatment. If substantially the whole of informed medical opinion is that in a given case a patient should have been given some particular advice or treatment, a medical man causing injury to a patient by failing to give such advice or treatment may become liable for his act or omission.

If a medical man charged with negligence has followed a practice or a method followed by a section of medical men but disapproved of by another section of medical men, then the doctor charged with negligence cannot be held to be negligent merely because he did not follow a practice pursued by the other section of medical men. Decided cases show that judicial notice is
taken of the fact that genuine differences of opinion and different practices and methods exist in the medical world.

It is a well-established principle that a doctor is not expected to be a miracle worker, but is required to show the diligence, skill and knowledge reasonably expected of an ordinary practitioner.

Negligence is multi-faceted term. It may suggest merely the single lapse, the error to which all individuals are prone or even a general inability to perform one's professional skills and carry out one's responsibilities. So observed Mr. Justice D. P. Waxhaw, president of the National Consumer Dispute Redressal Commission while disposing of the petition filed by Prafulla Kumar Das against Apollo Hospitals, Madras and others. There is a duty of care which doctor owes to his patient. When there is breach of that duty then harm follows as a consequence. Primary consideration is the diagnosis. A man may not possess the highest expert skill being there at the risk of being found negligent. It is a well established law that it is sufficient if he exercises the ordinary skill of an ordinary medical man exercising that particular art. The case of a medical man's negligence means failure to act in accordance with the established standards of reasonably competent medical men at the time.

The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such, failure as no doctor of ordinary prudence and skill would be guilty if acting with
ordinary care and negligence. This is called Bolam Test which was laid down in *Bolam vs. Friern Hospital Committee Case*\(^7\) A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular area. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of the informed medical opinion. Bolam test was approved by the Supreme Court.

With regard to the duties of the doctors to the patients, the Supreme Court in the case of *Dr. Laxman Balakrishna Joshi v. Dr. Trimbak Bapu Godbole*,\(^8\) observed that the duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by patient owes him certain duties viz. a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or duty of care in the administration of that treatment. A breach of any of those duties gives a right of action against the doctor's negligence to the patient. The medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor the lowest degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.

\(^7\) (1957) 2 All ER118
\(^8\) 1968 ACJ 183 at p 187 (SC)
In the petition filed by Prafulla Kumar Das father of the only 7-year-old son who died, he alleged that the death of his child was on account of medical negligence on the part of the Apollo Hospital Madras and the doctors who were attending on him. The child was suffering from VSD (Vascular Septic Defects) from his birth. Open Heart Surgery was performed on the child by Dr. Girinath, assisted by a team of doctors, the child died after about a month.

Das imputed negligence on account of several factors. But Dr. Girinath stated that surgery was successful and the repair was excellent. The child was daily assessed by a pediatrician, cardiologists and cardiac surgery. The National Commission considered the entire evidence and came to the conclusion that the father failed to prove allegation of any medical negligence leveled against the doctors. Moreover, Das did not bring on record any evidence to support his version. It was unfortunate that the child died but no responsible doctor would guarantee the outcome of any treatment. Cases of professional negligence, particularly, the medical negligence almost invariably turns on the expert evidence. Burden of proof lay squarely on the shoulders of the complainant to prove negligence on the part of the opposite party. The commission did not find any negligence on the part of the Apollo Hospitals Madras and doctors.

In another contrasting case against Dr. J. S. Arora, an orthopaedic Surgeon and Holy Family Hospital and New India Assurance Company Ltd., Manish Sood, a young Merchant Navy trainee claimed an amount of Rs.
13,78,800 - on account of salary and other perks. He was suffering from lumber disc prolapsed and was advised laminectomy of L4-5 region. He was operated upon by Dr. Arora attached at the Holy Family Hospital but he did not get any relief after operation. When X-ray and MRI were taken it was found that surgery was done at 43-4 region and not 4-5 regions. There was no relief to Manish after surgery. He was examined by Dr. (Col.) V. S. Madan, Senior Consultant Neurosurgeon, Sir Ganga Ram Hospital. Manish was operated upon by Dr. Madan and at the time of discharge his condition was satisfactory. Therefore his condition progressed, improved with the result he fully recovered. He joined his duties in the merchant navy after having undergone all traumas of two surgical operations.

On the basis of available facts and evidence the National Commission concluded that Dr. Arora actually did not operate upon the correct L4-5 intervertebral space - the primary preoperatively suspected site of disease in Manish. Thus Dr. Arora failed to detect and appropriately deal with the prolapsed disc lying between L4 and L5 vertebrae the real cause of spinal cord compression and disease systems. The National Commission keeping in mind the principle in the case of professional negligence particularly the Bolam Test, onus of proof, standard of proof and the evidence on record came to inescapable conclusion that Dr. Arora failed in his duty of care and committed breach of duty with the result that Manish suffered mentally, physically and monetarily. Therefore he was entitled to damages both general and special. The National commission awarded damages in the sum of Rs.
5.50 lakhs with interest @12% per annum on the amount of Rs.1.50 lakhs from the date of filing of the complaint. Both Dr. Arora and Holy family Hospital were held jointly and severally liable to pay this amount. Manish was also awarded Rs. 2000/- as costs. Out of the damages awarded, Rs. 5 lakhs was to be paid by the New India Assurance Company. In case of default in payment, the whole of the amount was to carry interest @ 18% per annum after two months from the date of the order till payment.

The above cases show that the complainant has to prove Doctors negligence conclusively through evidence and documentary proof to substantiate his allegation of medical negligence. Negligence is caused when the doctor fails to take all factors into account. However there must be direct connection between injury and ailment suffered and the treatment given.9

IV. Role and Functioning of Medical Councils in India:

The debates succeeding the inclusion of medical services under the ambit of the Consumer Protection Act 1986 have inevitably focused public attention on the question of accountability of the medical system and the institutional framework within which it operates. The concern is not unnatural when we consider the professional's proximity to the delicate division between life and death, ill health and physical well being. Unlike other professionals, doctors and nurses tend to step into people's lives when they are vulnerable

and to quit after making some attempt to restore health and hope in them. This is an idealized conception at best but one that clearly contributes to their appeal and heroism.

However, this image gets tarnished when it is contextualized in the everyday world of medical practice. An overwhelming majority of doctors (namely, practitioners of Allopathy, Homeopathy, Ayurveda, Unani and Siddha) are employed in an individual capacity in the profit oriented private sector, the sick do not receive medical care without making an on-the-spot payment. So central are monetary transactions to the healing process, and so repeated is the experience of it, that doctors have begun to resemble traders in the public eye and the services they render are seen as commodities to be purchased for a price.

Accompanying this altered image are reports of medical negligence, malpractice and unethical practices that have increasingly made their way into the mainstream media. With aggrieved patients and/or their crusading relatives taking doctors through the orchestration of civil and criminal lawsuits, the unquestioned trust that once underpinned the doctor-patient relationship has all but disappeared.

It is at this juncture that Consumer Protection Act, which admits medical suits into the speedier realm of consumer courts, has made its appearance. Reactions to the judgment have been sharp and the defensive
medical leadership has been unable to intelligibly counter the charges that have come up against them. It is obvious that the time for renewal has finally come, however vehemently it might be resisted.

Traditionally, the responsibility of regulating and disciplining the medical profession has been vested with the councils. Councils serve as gatekeepers between the state and the profession and between professionals and the public. They are facing a crisis of credibility at the moment. Since medical and nursing councils have not yet received the full attention of a sociological study in India, experiential accounts constitute the mainstay of conventional knowledge.

i) Genesis of Medical Council:

The facility of regulation of the medical profession, through the offices of a council, originated in the mid-nineteenth century in England. As recounted by Waddington (1984), the General Medical Council (GMC), which was constituted under the dictates of the Medical Act of 1858, was the outcome of a protracted struggle for radical reform in a profession deeply divided between the economically and politically powerful group of consultants and the relatively disenfranchised group of general practitioners. The Act served to uniformly bring all qualified medical practitioners under the governance of a single law and to elevate the organization of the profession to the national level. More importantly, it provided legal monopoly to these practitioners over all other healers. In return, the profession implicitly assured
potential patients quality of services. The vehicle through which this promise was sought to be lived out was a professional Code of Ethics to be enforced by the newly constituted council.

ii) Indian Medical Council:

The medical profession in India followed the example set in England, like many practices in medicine and nursing. The early registration Acts were legislated in Bombay, Bengal and Madras between 1912 and 1918. However, these were applicable only to practitioners of ‘western’ medicine (viz. Allopathy). The threat of non-recognition of Indian medical degrees by the GMC led to the creating of the Indian Medical Council in 1933. For such a council to be looked upon favorably by the British, it soon became obvious that its membership would have to be largely nominated and official. It was also evident that close association with indigenous practitioners would be incompatible with international recognition. Therefore, Acts designed to cover practitioners of Ayurveda, Unani and Homeopathy were legislated separately some 20 years after the first provincial acts. The decision to have separate councils and nominees at the helm of affairs is historical precedent that has had a crucial bearing on the framework within which regulation of the medical profession takes place.

iii) Separate Councils:

Each system of medicine is governed by a separate council at the central and state levels. In Maharashtra, for instance, allopathic practitioners
are governed by the Maharashtra Medical Council (MMC), homeopathic practitioners are affiliated to the Maharashtra Council of Homeopathy (MCH), practitioners of the Indian Systems (namely, Ashtang Ayurveda, Siddha, Unani and Tibb) fall under the purview of the Maharashtra Council of Indian Medicine (MCIM) and dentists are grouped under the Maharashtra State Dental Council (MSDC). The Maharashtra Nursing Council (MNC) and Maharashtra State Pharmacy Council (MSPC) are the bodies that regulate the Para-medical professions.

Similarly, all councils continue, to this day, to have a substantial proportion of nominated members, many occupying positions of power in the state bureaucracy.

iv) Legal Status of Councils:

Councils are legally constituted bodies. Legislation defines the scope and limits of their functioning. Since health appears on the concurrent list of the Indian Constitution, the Acts enacted by the central government complement and coexist with those legislated by the state. Legislation empowers councils to control the entry and exit of practitioners. This automatically brings into the picture, three major spheres of authority; medical education, registration and medical practice.

v) Medical Education:

For medical education to be considered legitimate, universities (or
medical institutions) and the courses offered by them need to be approved by
the councils. All the acts, especially those governing the central councils,
carry a list of approved qualifications and the universities in three schedules.
These schedules are not rigid but are open to new additions and removals.
How this can be done has been mentioned in the Acts and it appears as if the
central and state level councils have dual responsibility vis-à-vis universities
and colleges.

Interestingly, councils have only recommendatory powers in the matter
of medical education; the ultimate decision on recognition rests with the state
and central governments. This is particularly so in the matter of post graduate
education where the council's role is restricted to that on an adviser.

This is a limited role, to say the least, but one that is compounded in
the case of the MCIM, which is a council only in name. It is 13 years since a
radical restructuring was in sight, despite periodic representations by the
Registrar to the State Government.

In the recent past, the number of non-aided Ayurvedic and Unani
colleges in the state has been increasing at an alarming rate for reasons that
are not hard to see. According to the Registrar, private colleges with less than
optimum facility get recognition through their political connections. Thus, the
absence of a medical council has allowed the political-private college nexus to
thrive, which has, in turn, produced doctors with indifferent training.
vi) Registration Process:

After successfully completing a recognized degree in a recognized institution, new entrants into the profession are registered with councils. Councils comply with legally ordained registration systems, which show no uniformity. The MSDC, for example, levies an initial fee of Rs. 100 and follows it up with an annual renewal fee of Rs. 15 while the MCIM accepts a one-time payment of Rs. 500 and follows it up with mailed questionnaires once every five years. These differences have no apparent rational basis and revisions in the law do not come easily. The rupee value has been diminishing consistently and resultant loss of what could be a useful source of revenue has created permanent dependence on the state for monetary support. The cash strapped MSDC, is a case in point, which barely manages to pay its two employees and run its very modest establishment.

An activity that routinely engages almost all-clerical employees of the councils is the updating of the register. The maintenance of a credible register is problematic; although renewals are automatic upon payment of the renewal fee, deletion of members who may have expired or migrated does not routinely take place. Practitioners tend to be lax about re-registering themselves in the state to which they have migrated. As a result, registers are not always reflective of the geographical location of practitioners, which becomes crucial during elections.
Elections to councils take place by postal ballot with the register serving as the electoral list and the Registrar serving as the Returning Officer. The non-deletion of deceased or departed members from the register creates room for bogus voting.

The Council is expected to publish their registers every year. This does not happen in practice. The reason revolves around the inadequacy of funds. The only councils that have attempted to publish their register (with all the inherent inconsistencies) have been the MCH and MMC, largely due to their somewhat recent elections.

vii) Right to Practice:

The right to practice medicine, to hold office in institutions run by the government or local bodies, to sign or authenticate medical or fitness certificates and to give evidence at inquests or courts of law comes automatically to all duly qualified and registered professionals. To safeguard these rights, the central acts make provisions for punitive action against unqualified persons usurping them. However, this conviction has to be by a criminal court. This is ironic since it runs contrary to their monopolistic intent.

viii) A silent code:

All acts enjoin upon the councils to prescribe standards of professional conduct and etiquette through the design of a code of ethics. This serves two purposes; it provides practitioners with professional guidelines and secondly,
it sets the standards against which the nature and content of professional misconduct can be ascertained. However, the code of ethics remains, by and large, an unimplemented document. What is interesting is that even this document needs to be ratified by the Governor.

**ix) Disciplinary Actions:**

All councils at the state level are empowered to discipline the erring practitioners on their rolls and their inquiries enjoy the status of civil courts. This is the most dynamic aspect of their regulatory role. They cannot only enforce court attendance and examination under oath but can also compel the production and submission of documents, and issue summons for examination of witnesses. Disciplinary action may take place either through *suo moto* action instituted by the councils or in response to complaints from aggrieved patients. These have to be written and duly signed.

According to the acts and their rules, inquiries are unnecessary if the practitioner has been convicted by a criminal court or under the Army Act of 1950. In cases like these, the President is required to place before the council a copy of the judgment whereupon the council decides the punishment to be meted out.

In case of inquiry is felt to be essential, the council is required to serve a notice on the charged practitioner with details of the charges and copies of all relevant documents. The practitioner is asked to furnish a written
statement. All inquiries are held in camera where the onus of proof rests with the complainant.

It is here that council's task can be daunting. People who have approached councils for redress find themselves pitched against powerful lobbies, antagonistic court procedures, delayed judgments or summary dismissals. In a recent case filed in the MMC, the complainant maintained that the hearing of the case was conducted without reference to the medical records of the case. Not only that, he found that his statements had been altered to favor the accused doctors. Similar sentiments have been expressed by others also in the media.

Even the more obliging councils do not ordinarily divulge specific information about the charges made in each of the complaints coming to them and the *suo moto* action they have taken.

How many cases do councils handle in a year? How many have they had to deal with during the last five years? The Registrar of the MSDC, who has only recently been appointed, did not know the answer to this. However, discussions with the peon and clerk who have been there for a longer time revealed that an average of one case per year would have come up since 1990. The MCIM received two cases during the last five years. The MCH reported average five to six complaints per year.

On the whole, councils as disciplining bodies, are neither accessible to
the lay public not tough on fellow professionals. This appears to lack the
dynamic leadership that is willing and capable of bringing ethical issues into
the core of everyday practice. Their apathy is evident though their silence on
many of the burning issues of the day.

x) Limitations of Law:

Medical Councils are not really autonomous bodies. Further, councils
and the legislation under which they are constituted cover only those
practitioners who are part of the organized profession. Unqualified
practitioners-quacks, as they are commonly called-are untouched by the law.
This group includes not just unqualified doctors but nurses and other auxiliary
workers too. Therefore, the laws are restrictive in their scope.

However, when councils are asked about their disciplinary roles, they
become notoriously tightlipped. Health groups like the Medico Friend Circle
(Bombay Group) maintains that, in the past, the MMC has failed to produce a
record of action taken against erring doctors, even when forced to do so.

Whatever regulations take place is passive. Even if complaints are put
through the orchestrations of full-ledged inquiries, sufficient information on this
not available though, they rarely result in the enforcement of punitive
measures. The in-camera proceedings rule out the possibility of public
censure and de-registration rarely takes place. Therefore, the councils
function more as guild bodies protecting the self-interest than as regulatory
bodies, which enforce some social accountability in the profession. Some activists have labeled them as 'irresponsible trade unions' whose self-interest overrides public interest, others sat they have become 'virtually defunct'.

No matter how defunct councils may be, it is clear that we need them. The limitation of having no council is painfully evident in the case of the MCIM. However, the need for a radical overhauling of the entire system is evident. If councils are to become credible entitles they need to clean up their encrusted image.

Councils need to become more transparent and accessible to the public. The possibility of lay representation in the constitution of the council and a drastic reduction (if not total abolition) of state nominees and ex-officio members could be actively considered.

The existence of separate councils creates a divisive climate within which regulations take place. Issues on the cutting edge – for example, mishaps arising out of cross-practice, tend to get passed on from one council to another and unnecessarily delayed.

This argument finds some support among the office bearers of the Homeopathic council who additionally feel that there should be a common course for all medical students. According to them since the basic training in all the systems of medicine is virtually the same (save the aspect of
therapeutics), there should be a common course with specializations in Homeopathy, Allopathy or the Indian Systems of Medicine. They also endorse cross practice especially in rural areas where allopathic practitioners are not easy to find. However, they maintain that amendments proposed by them have never been taken seriously; only two out of 28 amendments submitted over the years have been accepted.

The possibility of decentralization of councils from the state to the district level also needs to be considered. This will make the task of maintaining a credible and a more manageable register. Information gathered at the district level can then be filed into the state register.

The system of automatic renewal of registration needs to be contingent upon performance or accumulation of credit in a Continuing Medical Education Programme. Secondly, the registration fees need to be rationalized in order to raise sufficient revenue from within the profession. This will reduce their dependence on state support.\(^\text{10}\)

V. Responsibilities of Doctors:

Duties of R.M.P (Registered Medical Practitioner):

1) Duty towards patient.

2) Duty to public at large & to abide by public policy.

3) Duty towards law enforcers.

4) Duty not to violate professional ethics.

5) Duty not to do anything illegal or hide illegal acts.

1) Duty towards patient:

i) Standard care:

Principle of standard care/ reasonable cares taken by average person doing similar reasonable job in similar reasonable situation of similar speciality.

(1) Due care & diligence of prudent RMP.

(2) Standard suitable, equipment in good repair.

(3) Standard assistants for example compounders, assistants, nurses and ayah etc. Principle of vicarious responsibility, master responsible for servant's acts, assistant is an agent of Master. Nonetheless agent can not do more than what master has delegated to him. Wherever State has prescribed qualifications for agents they must be complied with. Master is not responsible for criminal acts of their servants but responsible for civil acts.

(4) Standard drugs-Non standard drug is a poison by definition.


(6) Standard premises, where required registered e.g. Nursing home, hospital must comply with all laws applicable as imposed by state under Nursing home act, shop and establishment act.

(7) Standard Proper reference to appropriate specialist for
example radiologist, pathologist, pediatrician, Gynecologist, Orthopedic surgeon, etc.

(8) Standard proper record keeping for treatment given, surgery done, X-ray and pathological reports to be kept.

(9) Standard of not to experiment with patient.

(10) Anticipation of standard risks and complications and preventive actions taken time to time.

ii) Right of information by patient:

- Regarding natural documented complication of drug surgery, procedure, disease, investigation etc.
- Regarding necessity of treatment otherwise what will happen?
- Alternative modalities of treatment Ayurved, unani, siddha, Homeopathy, Naturopathy.
- Risks of not pursuing the treatment.
- Prognosis/has patient reached to point of no return? Explain it carefully taking in to account the emotional and psychological aspect of relatives e.g. Cancer patients, terminally ill.

iii) Regarding authorization of treatment:

Principle of prior informed consent by patient himself or legally authorized person.
(a) Specific consent:
   i. Patient specific.
   ii. Procedure specific.
(b) Information to patient: regarding indication, procedure, complications and prognosis.
(c) Preferably written consent is ideal.
(d) Signed by authorized person: natural parents, guardian or person above 18 years of age authorized patient.
   However, it is very important to note that Aunt or Uncle cannot give consent for nephew and niece. An insane person, minors, neighbor's and drunken persons consent is not valid.
(e) Proper witness to attest signature of authorized consent which is signed by one or two people.

iv) Right to know about expenses and its break up and duration of treatment required.

v) Guarantee of standard care service and not for the cure of disease or infirmity is held out of patients.

2) Duty of public:
   (1) Medical help when natural calamities like drought, flood earth quake occur
   (2) Medical help during train accidents
(3) Compulsory notification of births, deaths, infectious diseases, food poisoning etc.

(4) Help victims of house collapse, road accidents, fire etc.

(5) Duty to attend emergency and give first aid at least

3) Duty towards law enforcers: Police, magistrate etc.

(1) Inform police all cases of injury, illegal abortions, suicide, homicide, manslaughter, hurt, grievous hurt & its natural complications like tetanus, gas gangrene, etc. Includes vehicular accidents, fractures of bone and tooth.

(2) Inform police all cases of poisoning

(3) Inform police all cases of burns particularly importance given to female patients

(4) Call a magistrate for recording dying declaration.

(5) Inform bride burning and battered child cases.

4) Duty not to violate Professional Ethics:

(1) Not to associate with unregistered medical practitioner or employ medical practitioner of other faculty to allow him to practice what he is not qualified for.

(2) Not to advertise

(3) Not to issue false certificates & bills.

(4) Not to run medical stores.

(5) Not to write secret formulations.
(6) Not to refuse professional service on religious grounds.
(7) Not to attend patient under the effect or alcoholic drinks.
(8) No fee sharing (Dichotomy)
(9) Not to talk Loose about colleagues.
(10) Keep information given by patient as secret, not be divulged to employer, insurance company, parent of a major son/daughter without consent of patient, even in court where one does so under protest and in the interest of Justice.

5) Duty to avoid anything illegal or hide illegal acts:

(1) Performing illegal abortion.
(2) Issuing death certificates where cause of death is not known.
(3) Not to inform police a case of accident, burns, poisoning suicide, hurt, grievous hurt, tetanus, gas gangrene.
(4) Not to call magistrate for dying declaration.
(5) To do sex determination in State of Maharashtra and other states.
(6) Unauthorized, unnecessary, uninformed treatment and surgery or procedure.

VI. Rights of Doctors:

I) Prerequisite:

A duly qualified medical professional has a right to seek license to practice medicine, surgery, dentistry, ayurved, unani, homeopathy, sidha from
state/central council established for each faculty by union or state government by various legislative acts on payment of requisite fees and application in due form & annexures which are given for verification. All licenses/registrations are renewed on payment of fees at prescribed intervals. RMP must inform the concerned council about change of address and additional qualifications.

It is important to check whether ones registration is valid every 5 years with medical council. For non payment of renewal fees, ones registration is liable to be removed from state medical register.

ii) Rights of RMP (Registered Medical Practitioner):

1) Right to treat patients for the branch he is licensed.

2) Right to due compensation in terms of money & money only.

3) Right to full disclosure to information given by patient helpful for treating a patient.

4) Right to ask for any relevant investigation required to diagnose & and treat patient & seek its written compliance/refusal from patients.

5) Right to give instructions to patients, which should be followed, by patient regarding drugs, food, rest or any other relevant/necessary aspect and the diagnosis carried out by the doctor.

VII. Treatment of Patients and their rights:
The Consumer Protection Act 1986 enshrines the following rights of consumer:

- Right to be protected from hazardous goods and services
- Right to be informed about the quality and performance of goods and services
- Rights to free choice of goods and services
- Right to be heard in decision making process concerning consumer interests
- Right to redressal if consumer rights are infringed
- Right to consumer education

j) The Patient as a Consumer:

Traditionally, patients in India have unquestioning trust in their doctors. Most doctors deserve it. But in some cases, medical negligence has resulted in severe harm physical, mental and financial. In addition, unqualified practitioners have brought suffering to gullible patients. Doctors have been liable to prosecution in civil court, but few malpractice victims sue for compensation, fearing years (even decades) of costly litigation. Fortunately, in 1995 the Supreme Court decreed the medical profession to be a "service" under the Consumer Protection Act 1986. It set aside a Writ Petition challenging the same by the Indian Medical Association.

Medical negligence is defined as a failure to exercise reasonable skill and care in diagnosis and treatment as per the prevalent standards as that
particular point of time. An aggrieved patient who believes that he is a victim of medical negligence can now approach the Consumer Courts for fair compensation, and expect results in a relatively shorter period of two to three years. The procedure is comparatively simple and inexpensive.

**ii) The Patient's Rights:**

In the interest of a healthy doctor-patient relationship, a patient should know his rights as a consumer, according to the Consumer Guidance Society of India, they are as follows:

1. You have a right to be told all the facts about your illness; to have your medical records explained to you; and to be made aware of risks and side effects, if any, of the treatment prescribed for you, do not hesitate to question your doctor about any of these aspects.

2. When you are being given a physical examination, you have a right to be handled with consideration and due regard for your modesty.

3. You have a right to know your doctor's qualifications. If you cannot evaluate them yourself, do not hesitate to ask someone who can.

4. You have a right to complete confidentiality regarding your illness.

5. If you are doubtful about the treatment prescribed and especially an operation suggested, you have a right to get a second opinion from any specialist.

6. You have a right to be told in advance what an operation is for and the possible risks involved. If this is not possible because of your being unconscious or for some other reasons, your nearest
relatives must be told before they consent to the operation.

7. If you are to be discharged or moved to another hospital, you have a right to be informed in advance and to make your own choice of hospital of nursing home, in consultation with the doctor.

8. You have a right to get your case papers upon request."

VIII. Consumer Protection Act and medical negligence:

The Consumer protection Act 1986 (CPA) is a unique legislation which provides for speedy and economical redressal in a simple manner. It has been held in a number of cases under CPA that instances of medical negligence are covered by CPA. Given below is a brief of the provisions under CPA.

Those unfortunate enough to experience gross malpractice may approach (in writing or in person) the District Consumer Disputes Redressal Forum when the compensation claims amount to less than Rs. 20 Lakhs. Claims between Rs.20 Lakhs and Rs. One Crore may be taken to the State Consumer Dispute Commission. Claims above Rs. One Crore may be placed before the National Consumer Disputes Redressal Commission. The addresses of the above bodies may be obtained from the local consumer organization. All complaints must be endorsed by the written opinion of two expert specialists in the medical field.