CHAPTER-II
HISTORICAL EVOLUTION

INTRODUCTION

Human body is prone to ailments. Ailments take birth with the birth of the man. Man’s search for remedies and devices to preserve and restore health is as old as man kind. He has always been concerned with the maintaining the health and the question of survival, has compelled him to search out the solution to manifold problems of illness and diseases.

1. Position in India

A. Origin of Medical Negligence: in Ancient India

The concept of medicine and medical practices was prevalent in ancient India. India had a well-developed system of medicine called science of Ayurveda. The Holy Ramayana gives the instances illustrating the advancement of surgical skill and medical treatment in those days. In ancient India the system of medicine was indigenous (called Ayurvedic Chikilsa).

Dhanvantri has been regarded as an expounder deity of Ayurveda. Lord Dhanvantri appeared as an authority of Ayurveda possessing the stick (Danda) and water pot (Kamandal). One of the classical Vedic documents (comprising Rigveda, Yajurveda, Samaveda and Adharvaveda), Rigveda Samhita is the only primary collection, the other two being mainly derived from it. It contains a fairly elaborate account of the condition of medicine that prevailed in those days (about 700 B.C.). It provided the essentials for medical practice like administration of herbal drugs,

1 Charaka Samhita (3.8).
2 Charaka Samhita (4.6).
surgical operations, cure of skin ailment by Sunshine, Hydotherapy, etc… According to Rigveda, Rudra was the best of physicians (Bhisktamobhisajam) and Indra as protector and guarantor of life. The holy book referred above contains prayers to Indra for good health and protection from illness. Soma was the God who “healed whoever was sick.”

Notable works on medical science in ancient India are Charak Samhita, Sushruta Samhita and Vagbhata. Sushruta Samhita, a work comprehending the surgical tradition of Indian medicine, ascribed to the Sage Susruta, the original of which have been composed around 600 B.C. (G.N. Mukhopadhyaya.). It was one of the four treatises regarded as the source book for all the later surgical works in India.

Later Manusmriti laid down comprehensive measures for the protection of the layman from irresponsible Physicians. The penalties provided by the king in the cases of negligence of the physicians varied as per the severity of the lapse on the part of the physician and taking into account all other accompanying circumstances.

In both the Yajnavalkya Smriti and the Vihsnu Smriti fines were prescribed for the improper treatment by the physicians. The penalties imposed depended on whether a human or non-human suffered. It also depended on the class of the victim; higher the social class, higher the penalty. But Manu was never concerned with the class of the victim in inflicting punishment. Sushrutsamhita states that the physician should obtain the permission of the king before commencing the treatment.

A person was unqualified for practice without practical training. The practical training was to be carried on various objects for the purpose of learning so that the scholar did not experiment on human bodies. According to Charak Samhita, physician must have mastery over scriptures, experience, purity and cleverness. After undergoing a specified period of training and studying the science of medicine and its practical application a scholar would become the physician but before starting his

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3 Rigveda.
4 Bhishagratna, Kunja Lal; *Sushruta Samhita*, (1-2) ed., Calcutta (1907).
5 Manusmriti, IX.284
6 Sushruta Samhita 1-9
practice he was required to get permission of the king. In ancient Indian Society, there were certain principles of law, which regulated this profession by delimiting the freedom of practice and imposing certain restrictions as to qualifications, on scholars devoted to the science of medicine, teachers of medicine and physicians.

The *Arthasastra* also provided a code of ethics for physicians. If a physician while treating a person found that the disease is dangerous to the life, the matter should be informed to the authorities. If the person died, the physician had to pay a lowest fine, if death occurred due to any mistake on the part of the physician, and a medium rate fine will be prescribed by the king. If he died due to the negligence of the physician, the highest punishment would be inflicted. It was considered that the person treating a patient whether human or non human, was bestowed with a divine duty of care towards the patient. Apart from that, duties of physician were pre-fixed by the ancient documents.

### a. Duties of Physicians

Apart from the qualifications of physicians ancient literature speaks of professional ethics and Physicians duties and their liabilities for causing harm to the patients. Thus, the foremost duty of the Physician was to diagnose the disease very carefully and only after ascertaining the disease he could start the treatment with his ability and good sense.

Physician (*Vaidyas*) was not free to treat any person. There were restrictions on them to treat hunters, fowlers, out castes or sinners. Connecting on with the obligations of physician, *Sushruta Samhita* says that the physician had to sit down and examine his patient by sight, touch and questions. He had to diagnose properly and commence the treatment, if the disease was curable by him. Duties of physician were again confirmed through the relevant ancient documents.

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7  Charaka Samhita(3.8)
8  Charaka Samhita (3-8).
9  Ibid.
10 Supra, n.4.
11 Sushruta Samhita (1-2).
In Kautilya’s *Arthashastra*, it is stated that physician had to inform the administrative authority about the treatment to patients. If any physician took any person for treatment without informing the administrative authority called ‘gopa’ or ‘Sthanika’, he would be penalised. Therefore it was the duty of physician to inform the administrative officer about the treatment of an injury.

At that time, there were sufficient developments in medico-legal ethics to cope up with the problems arising out of medical profession. Kautilya’s work depicts a splendid picture of the legal duties and liabilities in medical profession. These are the concept of professional ethics, duties and liabilities of doctors specified in ancient documents. The concept of punishment had its own origin and development.

**b. Concept of Punishment**

Concept of punishment was specified in several literatures. The word “Mithya” has several meanings. It was applied according to the various situations. It means ‘false’, ‘wrong’ improper, error, illusive or incorrect. *Charak Samhita* used this word in the sense of wrong treatment.12 *Sushruta Samhita* uses the word “Mithyopachara” in the sense of improper conduct. It is stated that the physicians who act improperly are liable to punishment.13 Quantum of penalty varied according to the status of victim. As *Yajnavalkya Smriti* says, physician who acts improperly should, pay the first fine in the case of animals, the second highest in the case of man and highest in the case of kingsmen.14 Some of the classical literatures classified human-beings (for imposing penalty on physicians) into *Ragapurush*, *Rajamanush*, *Uttammaush* and *Madhyamanush*. Quantum of penalty varied according to the category to which the victim belonged. *Manusmriti* did not discriminate persons in this respect. It prescribed some penalty on the physician for improper treatment irrespective of the varna or category of victim. *Sushruta Samhita* stated that “If the death of patient under treatment is due to carelessness, the physician shall be punished

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12 Supra, n.4. Bhishgratna p. 370 314.
13 manav Dharmashashtra, 9 284.
with severe punishment, growth of disease due to negligence or indifference of a physician should be regarded as assault or violence"\textsuperscript{15}. These are the clear specifications in ancient literatures which relate to the specific enforcement of medical practice. Alternatively pecuniary penalties were also awarded. Fine as a form of punishment for improper treatment has a unique origin.

\textbf{c. Concept of Fine as Specific Form of Punishment}

Ancient Indian law relating to practice of medicine furnishes examples of penalties for injuries due to negligent treatment. Pecuniary penalty was based on the social status of victim, i.e., whether the victim of maltreatment was animal (horse, cow, elephant and so forth) or a person of the middle class or king’s retinue. Physician’s duty to care varied with the social status of the person under treatment, but degree of pecuniary penalty was not dependent on the degree of guilt. \textsuperscript{16} It was an absolute discretion of the judge to impose penalty, taking into account all factors.

The rules relating to the responsibility of physician for their improper medical treatment were not introduced merely to safeguard the patient, but also for good administration of the State. There is specific mention in \textit{Dharmashastras} and \textit{Arthashastra}, of the right of the patient to indemnify. The pecuniary penalty was imposed by the State and paid to the State (king). Thus, the law prevailing in ancient India sought to impose fines, which were deposited in the state exchequer, but no compensation was to be given to the aggrieved person. So one can see that fine for improper treatment has some historical importance.

\textsuperscript{15} \textit{Supra}, n. 4

\textsuperscript{16} \textit{Code of Hammurabi} (perhaps the oldest code) prescribed the law relating to the practice of surgery, it fixed the fee and penalties for improper treatment. “If a physician operates on a man for a severe wound with a bronze lancet and destroy the man’s eye, they shall cut-off his fingers”. “If a physician operates on a slave of a freeman for a severe wound with a broze lancent and cause his death, he shall restore a slave of equal value” “ if open an obseen(in his eye) with a bronze lancent and destroy his eye, he shall pay silver to the extent of one half of his prince” (These are the abstracts from J.M.M. Datta & H.K. Sahray., “Law relating to surgeons in ancient world”. Your health, vol.17 (1968) pp. 15, 20
From the above brief historical analysis it can be concluded that the legal order in ancient India was clearly supportive of the rights of patients against the negligence of physicians and improper medical treatments.

Now let us refer to the concept of medical negligence as it evolved under the common law.

II Position in England

A. Origin of Medical Negligence: in Ancient England

Origin of modern medicine was in ancient Greece. Greeks developed specialised categories of doctors by the fifth century B.C and had established medical schools. Though this period marked a move towards a more secular approach to cures, it also laid the basis for the divinity of healing.\(^\text{17}\) In the myth of Aesculapius, the Greeks invented different methods of treatment.\(^\text{18}\) According to legend, Aesculapius was the offspring of a God (Apollo, God of truth) and a mortal.\(^\text{19}\) Throughout Greece, temples and statues were erected in Aesculapiu’s honour, to which healers would come for inspiration and the ill for a cure. Like so many other myths cultivated by man, Aesculapius unwittingly performed a valuable social function. Through its “identification with a deity” this myth equipped the early physicians with the status to treat and to innovate. The writings of Hippocrates typified an emerging culture of paternalism and secrecy\(^\text{20}\). The notion of Hippocratic oath highlighted the dignity and decorum of medical profession.

The codification of medical ethics was crucial to its eventual professionalisation. Later the medical profession was institutionalized. The various codes promulgated throughout the centuries consistently emphasized the need of university practitioners to maintain a honorable facade to counter public apprehension of the degeneracy and


\(^{19}\) Ibid.

inconsistency of health care practitioners. The process towards professionalisation of health care in Greece suffered irreversible set back after the Roman conquest of the mediterranean. Later the education and practice of medicine came under the influence of the Christian church. Priests were urged to visit the sick and to cure, encouraged by the example of Jesus Christ’s missionary healing work. The early medieval monasteries made no obvious technical contribution to medicine, though they were responsible for humanizing and Christianising it as a healing and compassionate art.

Later institutionalization of medicine began with the establishment of universities throughout the twelfth and thirteenth centuries, which encouraged the codification of past customs. In Europe, the university was central to the eventual professionalization of medicine and by the end of the medieval period, a process that was endorsed by the papacy and complemented by advances in printing.

Stressing the dangers caused by the quacks and charlatans, the university doctors petitioned the state to delegate control over medical licenses and practice. In 1518, Thomas Linacre successfully obtained from Henry VIII letter of patent for a body of regular physicians which in 1551 became the Royal College of Physicians of London. These laws, under which the Bishop of London retained ultimate jurisdiction, decided who could practice in the city and within a seven-mile radius thereof, forbidding unlicensed or domestic practice.

Apart from that, the negative repercussion of scientific rationalization of health care are arguably and most keenly felt in the exclusion of the patient from the discourse of health care. The bid for public and State endorsement of the exclusive right of university doctors to practice was mirrored in Britain, though without the structured rivalry that existed in America.

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21 See Webb- people, Medical profession, Scorer & Wing Publication, (1979), pp.13-124
22 Ibid.
23 Supra, n.19.
Largely as a result of the British Medical Association’s persistent campaigning the Medical Act of 1858 finally granted General Medical Council the power to control medical practice in Britain, limiting it to those enrolled on the Medical Register. Many developed nations such as Britain shifted from fee-for service to “implicit rationing” through centralized budgetary procedures. Under the National Health Insurance Act, 1911 and the National Health Service Act, 1946 Central government budget fixed amount for community medical services on a capitation basis and hospital service on a global basis.

Medical defence bodies developed an attempt to protect licensed doctors and physicians from legal claims. Though there were a very few medical negligence actions, it “hit the headlines and were discussed prominently in daily news papers and medical journals”. The Medical Defense Union (“MDU”), founded by two solicitors and five “Gentlemen” was registered in Britain, under Companies Act, 1862 for preventing medical malpractices. But the concept and meaning of medical negligence in its modern sense is a later development.

**a. Definition and Meaning of Medical Negligence**

The prime object of the medical profession is to render service to humanity with full respect for the dignity of man. A doctor has a duty to use necessary skill, care, judgment and attention in the treatment of his patient. Any failure to exercise the above mentioned duty would lead to action for medical negligence. Regarding the definition of Medical Negligence, “Medical negligence is the breach of duty owed by a doctor to his patient to exercise reasonable care and skill, which results in some physical, mental or a financial disability.” Medical negligence law is generated chiefly by civil actions. Any crime of ‘gross negligence manslaughter’ has survived

26 Ibid.
27 Supra, n.21.
28 H.M.V. Cox, Medical Jurisprudence and Toxicology, Eastern Publication, New Delhi, 2001, p.16.
but is rarely prosecuted in the Health Care Context, and it would otherwise appear that instance of gross negligence are swiftly settled by the profession in private to minimize bad publicity. Later the concept of negligence changed accordingly.

**b. Concept of Medical Negligence**

‘Negligence’ was added to the common law in the seventeenth century with the increase of horse and buggy highway collisions. The beginning of the seventeenth century noticed a slow but steady transformation from an action of trespass on the case to an action for negligence. The concept of negligence in its present form is not of Indian origin but is patterned on English law, where negligence is a separate tort. Hence it is important to know the English position relating to the same.

In the beginning, it was considered as inadvertence as opposed to intentional dereliction of legal duty. Carelessness is actionable only when there is a duty to take care and when failure in that duty has resulted in damage. At the same time carelessness assumes the legal quality of negligence and entails the consequence in law of negligence. Every profession requires some specialized skill and learning. Persons involved in the exercise of the requisite skill could be liable for negligence if they failed to take that special care. In English law, the rule is *imperitia culpa annumerature* (want of skill is reckoned as a fault).

According to Winfield, in one form or another a fair amount of negligence in the sense of doing what a responsible man could not do, or not doing what he would do was covered by medieval law.

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31 *Donoghue v. Stevenson*, (1923) A.C. 562 per Lord Mc Millian.
32 *Ibid*.
In *R. v. Bateman*, the liability of physician and their duties was discussed. The court stated that if a medical practitioner holds himself out to be a skilled practitioner he is under an obligation to use the due caution, diligence, care, knowledge and skill in the treatment. The law requires a fair and reasonable standard of care and competence; irrespective of the fact that he is qualified or unqualified practitioner by a lower standard. He need not undertake to treat, if the practitioner considers it to be beyond his competence. It is also immaterial whether he rendered the service gratuitously or for reward. The standard of care and competence ought to be fair and reasonable one. It should neither be abnormally high standard nor a very low one. While adjudicating upon the standard of care to be observed by medical man, one should also have regard to some other relevant factors such as professional position, specialization, state of medical knowledge, development, availability of facilities, locality etc.

This was the stand adopted by English Court system.

Indian courts usually rely upon English decisions. Justice Tendolkar observed in 1947, that action for negligence in India are to be determined according the principles of English common Law. The said judgment was confirmed by Bombay High Court in appeal by Chagla C.J. and Bhagawati J. They observed that law on the subject in reality was not in dispute. The plaintiff has to establish first that there had been a want of complete care and skill on the part of defendant to such extent as to establish the necessary connection between the negligence of defendant and the ultimate death of plaintiff’s son.

These observations make it clear that negligent act must be the proximate cause of the injury sustained by the plaintiff. It is noticed that very few victims complained against negligence of medical men and even if they sue for damages the case is decided in subordinate or district level court and it seldom goes in appeal before the High courts. Number of cases decided in higher courts is negligible and

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34 1925 94 L. J. KB 791
35 *Supra*, n.18.
37 *Amelia Floudurs v. Dr. Clement pereria*, A.I.R. 1950 Bom
that too without laying down any new principle or theory with regard to liability in torts. The highest court of the country has affirmed the law laid down in Halsbury’s Laws of England.

A person, who holds himself out as ready to give medical advice or treatment, impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person whether he is a registered medical practitioner or not, if he is consulted by a patient he owes the patient certain duties namely a duty of care in administration of the treatment.\(^{38}\) A breach of any of these duties will support an action for negligence by the patient.

This principle has also been followed by the Hon’ble Supreme Court in Phillips India Ltd v. Kunjupunnu\(^{39}\) and others, relying on English decisions.\(^{40}\) Similar is the view of Madhya Pradesh High Court in J.N Shrivastava v Rambiharilal and others.\(^{41}\) It would appear from the above line of decisions that our courts have mostly relied on English decisions.

So the essential ingredients of actionable negligence in medical profession is (1) Existence of duty to take care whether it is so or not depends on the question of proximity\(^{42}\) (2) Breach of duty to take care (3) The breach of duty must cause the injury or loss to the defendant. For the analysis of these three components, comprehensive information regarding duty of care, Breach of duty of care and Injury arising out of breach of duty of care is needed.

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38 Supra, n. 24.
39 AIR 1975 Bom. 306.
40 Supra, n.36.
c. Duty of Care

According to Lord Wright no case of actionable negligence will arise unless the duty to be careful exists between Doctor and patients. This particular position created many problems. The English court stated that duty to take care arises when the relationship is established. This relationship may differ from case to case because the English Courts have not been able to evolve a formula of general application. This relationship need not necessarily be contractual one, but may also arise if the doctor accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly.

He owes a duty to the patients to use diligence, care, knowledge, skill and caution in administering the treatment. A person professing the Science of medicine represents to the world that he possesses the skill and competence to practice medicine. Relying on this representation, if somebody assents to the treatment and medical man does something to him, which is likely to cause physical injury unless done with due care, diligence and skill, he will be accountable for breach of duty to take care. Even if a medical man treats the patient out of moral obligation (Such as accident, sudden collapse etc.) the relationship is established and the duty continues until the need for care is over or some alternative arrangement is made. This is the sense of responsibility visualised through theory of responsibility. The concept of breach of duty needs more objective analysis.

d. Breach of Duty to Take Care

Breach of duty to take care means omitting to do something which a reasonable man would do, or doing something which he would not do. Standard of reasonable care is variable depending upon the state of knowledge and proficiency in medical skill at the relevant time. Any medical practitioner is expected to possess the requisite skill and competence in his profession. What was an excellent treatment a

few years back may be outdated now. Thus, failure to take care is to be interpreted as a failure to exercise reasonable skill and competence, expected of ordinary medical practitioner of ordinary prudence. A doctor cannot be held liable for a trifling injury if he has applied reasonable skill and competence, expected of ordinary medical practitioner of ordinary prudence. Lord Clyde\textsuperscript{44} brought in the concept of accepted practice in a case and opined that if the plaintiff pleads the failure on the part of doctor to adopt a particular course, which is regarded as accepted practice then he must prove that the course, adopted by the doctor was one that no professional man of ordinary prudence could have adopted in the ordinary course of practice. According to him, there is enough scope for genuine variation of opinion in the realm of diagnosis and treatment, and a medical practitioner does not become negligent merely because his opinion differs from that of other professional men. Thus the area of discretion is very wide. Moreover the absence of established principles in this respect creates many problems.

To be very brief it can be said that the failure to discharge the duties undertaken or arising from relationship between doctor and patient makes the doctor liable. So before commencing the treatment, the physician should examine the patient in an appropriate manner. Prescribing medicine on telephone in an emergency is not unreasonable provided the patient is examined as early as possible. During the time of treatment, failure in attending to the patient’s condition is breach of duty, because a doctor must attend to his patient with reasonable efficiency. Failure to do so would be a breach of duty.\textsuperscript{45} In another case on receiving emergency calls his duty is to leave everything in hand and rush to see the ailing patient whose condition might be serious. Doctor owes duty to supervise postoperative progress of the patient, whom he has operated, failing which he may be liable for breach of duty.\textsuperscript{46} Sometimes patient ought to be informed of certain things pertaining to treatment, which are likely to harm him. Warning of the risk involved in an operation must be given by surgeon.


\textsuperscript{45} Supra, n.29.

\textsuperscript{46} Chatterton v. Gerson, (1981) 1 All E.R. 257 Q.B.D.
Unreasonable delay in carrying out the treatment may amount to breach of duty. 47 So Practitioners are under an obligation to give necessary information about the patient under treatment, to the next doctor to whom patient has been referred or entrusted for treatment.

According to Lord Strachan, 48 if a doctor of limited experience, such as an ordinary house surgeon, suspected a condition, which would almost certainly endanger life unless attended to immediately, it was clearly his duty to refer the case to someone who had the necessary experience to deal with it. To refrain from doing so was a failure to take reasonable or ordinary care for the life of the patient. This was the position of sense of duty highlighted in common law system. According to Indian Law, it is the obligation of registrar, consultant and other persons involved in the treatment of a patient to see that their subordinate staff are suitably instructed and given necessary information regarding the treatment of the patient, failing which they may be liable in an action for negligence. 49 The wide unstructured concept of breach of duty cannot be enforced in the absence of effective guidelines.

Diagnosis of the patient is the very basis upon which whole of the treatment has to be carried out, mistaken diagnosis may result in wrong prescription, and wrong treatment causing harm or injury to the patient. Hence, failure to diagnose the patient properly amounts to negligence. 50 But medical practitioners are not infallible. Even a very highly qualified and experienced person may commit mistake in diagnosis, hence for every mistake in diagnosis he is not to be held liable. He can be liable, where he fails to do according to the reasonable standard of care.

Mistaken diagnosis is not necessarily negligent diagnosis, unless the symptoms are so apparent that any reasonably competent and skilful physician could say that ‘this is disease’. Diagnosis must also be judged in relation to development in

47 Clark v. Meclennon, (1983) 1 All E.R. 418 Q.B.D.
49 Consmopolitan Hospital Pvt Ltd & Others v. V.P. Shantha and Others, 1992 (1) CPJ 302, 1992(1) (C) CPR 820. 1993 CCJ 198 (NCDRC)
50 Gold v. Haringey Health Authority, (1987) 2 All ER.
science of medicine at that time. If he fails to observe the later developments and adheres to original mistaken diagnosis, he may be held to have been negligent. Mistakes are excusable, if they are errors which any doctors of normal prudence might be expected to make.\(^{51}\) Since no general principle has been evolved, so as to form the basis of these circumstances which give rise to the physicians duty to care, the court has through the decisions over a number of instances evolved a jurisprudence where duty to take care exists. The position may be summarized as follows.

1. Physician being in a fiduciary position owes duty to be careful while undertaking to treat or heal a person. His duty is to act with utmost good faith towards the patient. He must refuse to give treatment if he cannot accomplish a cure or the treatment, which will be of any benefit to the patient.

2. Doctor’s duty is to be very in careful in diagnosing the patient’s disease and acquaint him of the treatment to be given or operation to be performed.

3. Physician ought to give proper instructions and warning to the patient, which he ought to observe during the treatment and dosage to be taken.

4. Physicians are under obligation to give to the patient proper care during treatment and after treatment with due diligence. In other words it can be said that patient should not be abandoned.

5. It is the duty of physician to make true and full disclosure as to the illness, treatment and risks involved in treatment.

6. It is the legal duty of every practitioner to take informed consent of patient.

In very few circumstances where physician or doctors had the duty to take care, it is implied that a person seeking information from another, who is possessed of a special skill, trust him to exercise all due care and that party knew or ought to have known that reliance was being placed on his skill and judgment. Duty to take care has been explained in *Donoghue v. Stevenson* by Lord Atkin who profounded

\(^{51}\) *Maynard v. West Midland Regional Health Authority*, (1985) 1 All ER. 635 H.L.
neighbourhood principle according to which one must take reasonable care to avoid acts or omissions that he can reasonably foresee would be likely to injure his neighbours.  

In the above observation the rate of reasonable foresight as criterion of negligence seems to have been conceived, wherever a physician or doctor foresees that his acts are likely to affect others, he owes duty to take care. The foreseeability on the part of physician or surgeon does not mean extraordinary foresight but reasonable one, therefore, a medical practitioner will not be responsible for the injury caused by his acts or omissions, if it is not foreseeable by a reasonable man.

Reasonableness of foresight of a medical man is to be determined according to the medical knowledge and practice approved at that time. In Roe v. Minister, two patients suffer spinal paralysis following injections. Ampules of injections were stored in phenol and it developed invisible cracks, in consequence of which phenol percolated in the ampules, which caused spinal paralysis to the plaintiff. The court held that having regard to the state of medical knowledge at the relevant time the doctor was not negligent in having taken no precaution to guard against such a risk. The law neither expected highest degree of care nor the lowest, but of a man of responsible prudence, of the same profession, in similar circumstances.

There is no justification in pleading that some other doctors could have done better. The standard of care is flexible and adaptable to circumstance because the same standard of skill or competence is not expected of every medical man that is why the standard of responsible care cannot be defined with mathematical precision. Reasonableness of care depends on numerous factors like advancement of science of medicine, time, place and experience etc. It must be the standard of care and skill, which any medical man exercising the professional skill ought to observe.

52  Supra, n. 31.
Medical practitioner 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 act, merely because there was a body of opinion that would take a contrary view.\textsuperscript{54}

Thus the judicial decisions affirm that the standard of care required of medical man is that of the average practitioner of the category (e.g.: Allopathic, Homoeopathic, Ayurvedic, etc.) to which the negligent practitioner belongs. As already noted, fair and reasonable standard of skill and competence is variable because some people may be more skilled and some may have only the lowest standard of skill and competence.

The yardstick is the degree of care, which may be reasonably expected of a practitioner of average skill depending upon the actual circumstances of the case. The patient by being obstructive or difficult may complicate treatment and produce unforeseen results; the time, place and the circumstance prevailing there are important in assessing the degree of care which may reasonably be expected. A practitioner, who is called to a remote country cottage at night, in an unexpected emergency, cannot be expected to achieve the same standard, which can be expected in a well-equipped hospital with adequate trained staff and appliances where lives saving drugs are immediately available.\textsuperscript{55}

Thus, the question of reasonableness of standard is objective, which is to be determined by court, taking into account numerous factors. Lord Denning who has attained masterful position in medical negligence cases made a very pertinent observation about standard of care.\textsuperscript{56} A doctor was not to be held negligent simply because something went wrong. He was not liable for mischance or misadventure or for error of judgment. He was not liable for taking one choice out of two or for favouring one school rather than other. He was only liable when he fell below the

\textsuperscript{54} Bolam v. Friern Hosp. Management Committee, (1957) 1 W.L.R. 582,587 per Mc, Nair. J.
\textsuperscript{56} Husks v. Cole, (1968) 118 New. L.J. 469.
standard of a reasonably competent practitioner in his field so much so that his conduct might be deserving of censure or inexcusable. This was the concept of reasonable foreseeability principle, in common law system. This needed careful judicial observation and subsequent effective legislative guidance for the matter of foreseeability theory.

The tort of negligence chiefly operates under a model of fault liability, which is broken down into various components of proof. The plaintiff must prove that in the circumstances the defendant owed him a duty of care; the defendant breached that duty by failing to meet a standard of care required by law; and that the defendants breach of duty caused the plaintiff to suffer injury or harm for which compensation may be recovered at law.\(^5^7\) For determining whether a defendant owned a duty of care to the plaintiff, the courts will often pose the question as whether in that circumstances it was ‘reasonably foreseeable’ that the plaintiff would be injured; was it considered proof of causation for that ‘reasonable foreseeability’ of injury becomes a critical factor in considering breach of duty.\(^5^8\)

Again the concept of fault analysis was highlighted recently in Bolitho \textit{v.} City & Hunckey Health authority, \(^5^9\) where the professional standard of care or Bolam test was controversially applied by the House of Lord in considering whether caution was proved.\(^6^0\)

Lord Brawne- Wilkinson\(^6^1\) accepted that this was exceptional but necessary where proof of casual link between the defendants omission and the plaintiff’s injury requires the court to assess what would have happened had the defendant not breached his duty to act (and in this case attended the patient) .To ascertain as a matter of likelihood how the defendant would have acted in the hypothetic event

\(^{57}\) The link was exemplified by Lord Denning in \textit{Roe v. Ministry of health} (1954) 2All ER. 131 at 138
\(^{58}\) \textit{Ibid.}
\(^{59}\) All ER. (1998) 4 A.C.23.
\(^{60}\) \textit{Ibid.}
\(^{61}\) \textit{Supra}, n.59.
of having attended the patient, it was necessary to consider the relevant approved medical practice which one would have expected him to follow.\textsuperscript{62}

In \textit{Jaiprakash Saini v. Director Rajiv Gandhi Cancer Institute & Research Center}, \textsuperscript{63} it has been held that in order to decide whether negligence is established in any particular case, the alleged act or omission or course of conduct, complained must be judged not by ideal standard nor in the abstract but against the background of circumstances in which the treatment in question was given and the true test for establishing negligence on the part of a doctor is that whether a doctor of ordinary skill would be guilty if acting with reasonable care. Merely because a medical procedure fails it cannot be stated that the medical practitioner is guilty of negligence unless it is proved that the medical practitioner did not act with sufficient care and skill and the burden of proving the same, rests upon the person who assists it. So the duty of a medical practitioner arises from the fact that he does something to a human being, which is likely to cause physical damage unless it is done with proper care and skill.

\textbf{e. Meaning and concept of Injury}

Plaintiff must have suffered injury due to the breach of duty to take care. The term injury is of wide importance and it connotes conjunction of \textit{damnum} (i.e., loss) and \textit{injuria} (i.e. a legally recognized wrong). The injury or loss must have been the resultant of wrongful act of medical practitioner involving breach of duty to take care and its breach causing damage are the constituents of negligence.\textsuperscript{64} Court observed that, mere sequence of causes and effect is not enough in law to constitute a cause of action in negligence. Injury is a complex concept, involving a duty as between the parties to take care, as well as a breach of that duty and resulting in damage.\textsuperscript{65} Once it is established that the act or omission of defendant amounting to breach of duty to

\begin{footnotesize}
\textsuperscript{63} 2003 (2) CPR.205.
\textsuperscript{64} Supra, n.57.
\textsuperscript{65} Grant v. Australian knitting Mills (1936) AC pp. 85-103
\end{footnotesize}
take care is the proximate cause of injury or loss suffered by plaintiff, the duty of
courts is to measure the loss or damage in terms of money and award the same to the
plaintiff. Frivolous action must be dismissed at the outset. The criteria for the purpose
of fixation of compensation are unguided and not according to any guidelines.

The damages payable by negligent doctor need not be for the injuries which
are the result of a breach of duty within proximity as enunciated by Brett M.R.J. in
Heaven v. Pender\(^{66}\) “whenever one person is by circumstances placed in such a
position with regard to another that everyone of ordinary sense who did think could at
once recognize that if he did not use ordinary care and skill in his own conduct with
regard to those circumstances he would cause danger of injury to the person or
property of the other, a duty arises to use ordinary care and skill to avoid such
danger”. Later on Lord Atkin approved this principle, by laying down the neighbour
hood rule, which has already been mentioned earlier.

The ambit of duty of proximity established in Donoghue v. Stevenson\(^{67}\) is being
gradually enlarged, however it cannot be used to include the things, which are too
remote. Because the maxim “Jura non remote causa sed proxima spectacular” means
that the law regards only that cause as proximate which is not remote. Mere evidence
of the fact that the doctor deviated from approved practice of medicine or gave
improper treatment is not conclusive. It must be proved that the improper treatment or
deviation from approved practice was the proximate cause of injuries sustained.

This area is not under specific guidelines. It is high time to make a proper law
related to the matter of “improper treatment.” In India the development of law relating
to the matter of compensation is inadequate and unguided. So there is a need for a
comprehensive law relating to the matter of injury and compensation.

\(^{66}\) (1883) 11 Q.B. D pp. 563, 359.
\(^{67}\) Supra, n. 31.
111. Constitutional perspective of Right to quality Medical Care and Subsequent evolution of Law

The Constitution of India not only provides for the health care of the people but also directs the State to take measures to improve the condition of health care of the people. The preamble to the Constitution of India secure for all its citizens justice social and economic. The Constitution provides a framework for the achievement of the objective laid down in the preamble.

The right to health has not been integrated directly into the Constitution of India. The only right that is related to right to health is the right to life guaranteed under the Constitution \(^68\). The Indian Supreme Court by its innovative judicial interpretation of the various provisions has given a new content and scope to the right to life, which has come to stay as a sanctuary for human values. The Supreme Court has interpreted the right to life as embracing the right to live with human dignity, which included the quality of life along with all the basic human needs such as food, clothing, shelter, safe drinking water, education and health care. \(^69\)

In *State of Punjab v. Mohinder Singh Chawla*\(^70\) it was declared that since the right to health was an integral part of the right to life the Govt has a constitutional obligation to provide health facilities. Similarly in *Mr: ‘X’ v. Hospital ‘Z’*\(^71\) the Supreme Court held that the right to life includes the right to lead a healthy life so as to enjoy all facilities of human body in their prime condition.

In a similar view, in *Chameli Singh v. State of U.P*\(^72\) it was held that the right to life implies the right to food, water, decent environment, education, medical care and

\(^{68}\) Article 21 of the Constitution, which declares, “No person shall be deprived of his life or personal liberty except according to the procedure established by law”.

\(^{69}\) Francis coralie Mullin v. The administration Union Territory of Delhi A.I.R. 1981 SC 746 at p.753.

\(^{70}\) (1997) 2 SCC 8371.

\(^{71}\) A.I.R. 1999 SC 495

\(^{72}\) A.I.R. 1996 SC 1051
shelter. These are basic human rights known to any civilized society. The civil, political; social and cultural rights enshrined in the Constitution cannot be exercised without these basic rights.

The Supreme Court, in *Paschim Banghakhet Mazdoor Samity and others v. State of West Bengal and another*\(^73\), while widening the scope of Art: 21 and dealing with the government responsibility to provide medical aid to every person in the country, held that in a welfare State, the primary duty of the government is to secure the welfare of the people. Providing adequate medical facilities for the people is an obligation undertaken by the government in a welfare State. So it was contented that the petitioner should be suitably compensated for the breach of his right guaranteed under Art: 21 of the Constitution. After due regard to the facts and circumstance of the case, compensation was awarded. The *Paschim Banga*\(^74\) reiterates the position that the right to medical services is part of the right to life and the State has a duty to provide it either through the State machinery or through the private sector.

Later in *Paramand Kattara v. Union of India*\(^75\) the court made only a declaration that legal or procedural technicalities cannot stand in the way of the doctor providing emergency medical care to accident victims. Eventhough this decision does not impose any positive obligation on doctors of private hospital to provide medical treatment to accident victims; it was an effective decision for the enforcement of the right of patient.

The court again in *Vincent Panikulangara v. Union of India*\(^76\) held that, ‘a healthy body is the very foundation for all human activities’. In welfare State, it is the obligation of the State to ensure the creation and the sustenance of conditions

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\(^73\) (1996) 4 SCC Art 21 imposes an obligation on the state to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The government hospital run by the state is duty bound to extent medical assistance for preserving human life. Failure on the part of the government hospital to provide timely extend medical assistance

\(^74\) Ibid.

\(^75\) A.I.R. 1989 SC. 2039

\(^76\) A.I.R. 1987 SC. 994
congenial to health. Even though this is the recommendation of highest court in India, State and its health machinery system is unable to enforce any strategy for providing quality medical aid to those persons who needed the service.

The court further stated in a series of pronouncements during the recent years that right to health has been carried from the provision of part IV of the Constitution\textsuperscript{77} and this cast a duty on the State to raise the level of nutrition and the standard of living and to improve public health. These directive principles are only directive to the State. These are non-justifiable. No person can make claim for non-fulfillment of these directives. But at the sometime if any of the fundamental rights is not fulfilled, then a person can claim those rights as a matter of right and State can be made liable for non-fulfillment of these rights. The effective enforcement of right to health through writ jurisdiction is not at all accessible to common man because of expensive cost of litigation. At the same time it could not be implemented through the court as merely a Directive Principle of State Policy.

The observation in \textit{Paramand Kattara}\textsuperscript{78} created a new right- the right to get medical aid and it has become an integral part of the right to life guaranteed under Art; 21 of the Constitution. The Supreme court in \textit{Consumer Education and Research Centre v. Union of India}\textsuperscript{79} has reiterated this stand. In this case the issue was regarding health problem and the right of labourers to get adequate medical aid. While answering this question, the court said “the facilities and opportunities that are enjoined in Art 38 should be provided to protect the health of the workmen. It was held that the right to health and medical aid is a fundamental right under Art: 21 read with Art. 39 (c), 41 and 43 of Constitution and to make the life of the workmen meaningful and purposeful with dignity of person. Right to life, which includes protection of the health and quality medical aid, is a minimum requirement to enable a person to live with human dignity.\textsuperscript{80}"

\textsuperscript{77} Art: 47 of Indian Constitution “The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and in particular, the state shall endeavour to bring out prohibition of the consumption except for medical purpose of intoxications drinks and of drugs which are injurious to health”

\textsuperscript{78} Supra n.75.

\textsuperscript{79} (1995) 3 SCC 42

\textsuperscript{80} Ibid.
The Supreme court, while examining the issue of the Constitutional right to medical aid under Art: 21, 41, and 47 of the Constitution of India in *State of Punjab v. Ram Lubhaya Bagga*, observed that the right of one person correlates with a duty upon another individual, employer, government or authority. Hence, the right of a citizen to live under Art: 21 is an obligation on the State. This obligation has been reinforced through Art: 47, as its primary duty. No doubt, the government is rendering this obligation through health centers, but to be more meaningful they must be within the reach the people.

Every citizen of this welfare State looks towards the State to perform this obligation effectively in a number of ways, including by way of allocation of sufficient funds. State should evolve the necessary legal machinery for handling the issue relating to the matter of negligence or intentional negligence from the part of hospital authorities, doctors and accessory staff. These in turn will not only secure the rights of its citizen to their satisfaction but will benefit the State in achieving its social, political and economic goals. In addition to the Constitutional developments the international conventions and other obligations have a direct impact on the Indian health conditions, in view of India’s commitments to abide by and implement the Treaty obligations and the ratifications made by it under Article 51 of the Constitution.

**IV. Evolution of medical care law through Human Right Jurisprudence**

The right to medical care is an age-old phenomenon. Adoption of the Human Rights paradigm has the potential to revolutionize the health field. It is inconceivable to separate health and human right and they need to be integrated into all aspects of health care. Human Rights violation has a negative impact on health. Indian conceptualization of human right can best be exemplified in the *vedic* prayer “*Sarve Sukhinath sarve-santhi Niramayah*” may everybody in this universe be happy and

healthy. This principle highlights the global and multidimensional nature of our commitment to the protection and preservation of human rights. The most important right relating to the body of human person is the right to health and this found place in the realm of human rights even from earlier days. There are several international documents which discusses these principles- which we will look into in the next segment.

(A.) International Efforts for Health care protection

The right to medical care, as an international human right, is founded on the edifice of the prescription of the United Nation Charter, the International Bill of Rights, the


83 Article 55 and 56 of United Nations Charter Article 55. With a view to the creation of condition of stability and well being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self – determination of people, the United Nations shall promote.

(a) Higher standards of living, full employment, and condition for economic and social progress and development.
(b) Solution of International economic, social, health and related problems: and international cultural and educational co-operation; and
(c) Universal respect for and observance of human rights and fundamental freedom for all without distinction as to race, sex, language or religion.

84 Art 25(1) of Universal Declaration of Human Rights. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment sickness, disability, widowhood, old age or other lack of livelihood in circumstance beyond his control. Article 12 International covenant on Economic social and cultural rights.

(1) The states parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
(2) The step to be taken by the states parties to the present parties to present covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the still birth- rate and of infant morality and for the healthy development of the child:
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of condition, which would assure to all medical service and medical attention in the event of sickness.
Convention on Elimination of All Forms of Discrimination against Women 1979\textsuperscript{85}, the United Nations Convention on the Right of the Child, 1989 etc\textsuperscript{86}. Therefore, the members of the international community are expected to build their health care

\begin{itemize}
\item[85] Art 14 of the convention on Elimination of All Forms of Discrimination against Women 1979.
\begin{enumerate}
\item The states parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non monetised sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of this convention to women in rural areas.
\item State parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and in particular, shall ensure to such women the right:
\begin{enumerate}
\item To participate in the elaboration and implementation of development planning in all levels;
\item To have access to adequate health care facilities, including information, counseling and service in family planning.
\end{enumerate}
\end{enumerate}

\item[86] Art 24 (1) United Nations Conventions on the Right of the Child, 1989
\begin{enumerate}
\item States parties to recognize the right of the child to the employment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States parties shall strive to ensure that no child is deprived of his or her right of access to such health care service.
\item State parties shall pursue full implementation of this right and, in particular, shall take appropriate measures;
\begin{enumerate}
\item To diminish infant and child morality;
\item To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development primary health care;
\item To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking – water, taking into consideration the dangers and risks of environmental pollution.
\item To ensure appropriate pre-natal and post-natal health care for mothers;
\item The ensure that all segments of society, in particular parents and children, are informed, have access to education and care supported in the use of basic knowledge of child health and nutrition, the advantage of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
\item To develop preventive health care, guidance for parents and family planning education and services.
\end{enumerate}
\item States parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
\item States parties undertaken to promote and encourage international co-operation with a view to achieving progressively the full realization of the rights recognize in the present article. In this regard, articular account shall be taken of the needs of developing countries.
\end{enumerate}
strategies on this edifice. These international documents provided ample recognition for right to medical care and quality treatment.

a). The Scheme of United Nations Charter

The Human Rights provision of the United Nation Charter does not explicitly deal with health as a Human Right. The charter declares that the promotion for respect of human right and fundamental freedom is the purpose behind the establishment of the United Nations Organization.

To achieve this purpose, the United Nation is charged with the responsibility to promote, interalia higher standard of living, full employment, condition of economic and social progress and development and solutions to International economic, social, health and related problems. In a similar vein, the member states are obligated to act in co-operation with the United Nations organization for the achievements of the declared purpose.

(b) The Scheme of International Bill of Rights

Pursuant to the call of the United Nation Charter for the promotion of “human rights and fundamental freedom”, International community adopted on 10th December


88 See. The charter of United Nations, Article,1. The purposes of United Nations are

1. To maintain international peace and security and to that end: to take effective collective measures for the prevention and removal of threats to the peace, and to bring about by peaceful means, and in conformity with the principle of justice and international disputes, adjustment or settlement of international dispute or situations which might lead to breach of the peace.

2 To develop friendly relation among nations based on respect for the principle of equal rights and self- determination of people, and to take other appropriate measures to strengthen Universal peace:

3 To achieve international co-Operation in solving international problem of an economic, social, cultural or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedom for all without distinction as to race, sex, language, or religion and

4 To be a center for harmonizing the actions of nation in the attainment of these common ends.

89 Supra, n. 83.
1948 the Universal Declaration of Human Rights, which came into force in 1976.  

(c) The Universal Declaration of Human Rights

The adoption of the Universal Declaration of Human Rights by the United Nation General assembly brought Human Right revolution in the World. Declaration proclaims that all human beings are born free and equal in dignity and right and they are entitled to a social and international order in which the rights and freedom set forth in this Declaration can be fully realized. The declaration expressly recognized the right to health.

(d) The Scheme of International Covenants on Human Rights

The International Covenant on Economic, Social and Cultural Right embodies the second-generation human rights, which are positive in scope and character, imposing positive and affirmative obligation on the State parties. It embodies the right to health comprehensively in Art12.

The International Convention on the Elimination of all Forms of Racial Discrimination 1965 confers on member state a more effective positive obligation with regard to medical care. Similarly Convention on Elimination of all Form of Discrimination against Women 1979, in Art: 12 requires state parties, interalia to take all appropriate measures to eliminate discrimination against women in the field of medical care in order to ensure, on the basis of equality of men and women, access to

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90 Universal Declaration of H.R. 1948 Art: 1
91 Ibid. Art: 25 aims to guarantee the preconditions of good health, inducing the availability of health service Art 25(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or others lack of livelihood in circumstances beyond his control.
93 International Covenant on Economic, Social and Cultural Right, 1996, Art: 10(3) Art: 11 and Art: 12(1)
94 Supra, n. 85.
medical services, including those related to family planning.\textsuperscript{95}

The United Nations Convention on the Rights of the Child, 1989 requires that the State parties shall recognize the right of the child to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such medical care service.\textsuperscript{96}

The European Social Charter\textsuperscript{97} and American Declaration of the Right and Duties of Man\textsuperscript{98} also deal with right to preservation of health. The Constitution of the civil and socialist countries of the Hemisphere also includes a statement on the rights to

\textsuperscript{95} The Convention on the Elimination of All Forms of Discrimination against Women 1976. Art 12(1) states parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure on the basis of equality of men and women, access to health care services, including those related to family planning.

\textsuperscript{96} Convention on the Rights of the Child, 1989, Art 15 Freedom to manifest one’s religion or belief may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedom of others.

1. States parties recognize the right of the child to freedom of association and freedom to peaceful assembly.
2. No restriction may be placed on the exercise of these rights others than those imposed in conformity with the law and which are necessary in a democratic society or public safety public order (Order Public), the protection of Public health or morals or the protection of the rights and freedoms of others.

\textsuperscript{97} European social Charter: 1961

PART-I
Every one has the right to benefit from any measure enabling him to enjoy the highest possible standard of health

PART –II

Article-II: The right to protection of health with a view to ensuring the effective exercise of the right to protection of health, the contracting parties undertaken, either directly or in co-operation with public or private organization, to take appropriate measure designed inter alia: -

1. To remove as far as possible the causes of ill health
2. To provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health.
3. To prevent as far as possible epidemic, endemic and other diseases.

\textsuperscript{98} See American Declaration of Rights and Duties of man 1948.

Article: II: - Right to the preservation of health and to well-being.
Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extend permitted by public and community resources.
health including medical care and the duty of the state in regard to the health of the nation.  

Right to medical care like all other human Rights, is an internationally recognized legal right, prompting domestic legal systems to provide for their automatic judicial enforcement. A classic example of this is India where the Indian Supreme Court has accorded judicial recognition and importance to various human rights embodied in the International Instrument to which India is a party.

There have been other international effort for the realization of the right to health care. The World Health Organization has played a pioneering role for the last few years in guiding the health policy, development, and action at the national and global level. The main objective of the World Health Organization shall be the attainment by all people of the highest possible level of health.

The term ‘deficiency’ in medical services should extend beyond the discriminating definition give under the Consumer Protection Act, 1986 for the purpose of promoting Human Rights. The foundation of this term in fact forms the concern expressed by the International Organization for Consumer Union (IOCU) and the United Nations Guidelines on Consumer Protection. Failure to provide safety of product used in medical care service, experimental medicine and clinical trails on human being and abuse of diagnostic and curative procedure can also lead to Human Right violation. Access to medical care records in commercial transaction in human organs and research involving human embryo or human cells also need to be evaluated in the context of human rights law principles. There are several areas of medical service where violation of Human Rights has been notified. Some instances are discussed below.

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100 Apparel Export Promotion Council v. A. K. Chopra A.I.R. 1999 SC 625
101 supra, n.92.
102 For the definition of the term’ deficiency’ see Section 2 of the Consumer Protection Act, 1986.
v. Access to Health Care System

A. Access to Health Care Services

Civilized countries world over, consider availability of basic medical facilities as a part of the individual rights. The Indian Constitution declares the right to life as an important Fundamental Right. The duty to provide quality medical facility is a Constitutional mandate under the Directive Principle of State Policy. The court has again reminded the State about its positive duty to provide conditions for meaningful life to all people. This positive duty includes the duty to provide reasonable facilities for medical care.103 Another issue in this connection is the suspension of medical service either for personal reason or as a form of collective action. When a doctor either by himself or through collective action involving other doctors etc willfully refuses to provide service -it is a gross abuse of right to life of hundred of patients and a denial of access to health care services. The remark made by Lory Backer that the “Hippocratic oath taken by the doctors has turned out to be a hypocrisy”, is very meaningful in this context. It is necessary that there is proper check on such unfortunate instances, for promoting human right protection.

B. Access to advanced medical treatment

Progress in modern medical science & technology has helped humanity to overcome many condition of ill health, which was previously considered to be incurable. Many of these procedures and treatments are highly expensive and unaffordable to the common man. Some of the developments include life saving procedures like Kidney, Liver, and bone-marrow transplantation. Even though the procedures are expensive it may help to save the lives of many. Apart from the expenses involved, transfer of live tissues from one man to another involves moral and ethical questions to be decided based on human right aspects. Many non-regenerating human tissues like Kidney, heart and cornea are capable of helping even terminally ill patients but their availability is limited.

The alternative mechanism suggested is to look for cadaveric, which may lead to large-scale exploitation. This constitutes another area of medical malpractice. Many civilized countries of the world including India have gone in for control over human organ transplantation. Very often-administrative procedures are envisaged for monitoring the process. 104

So it may be possible to argue that to prevent chance of abuse, strict vigilance is a must. Thus attempts ought to be made for creation of proper machinery to coordinate all these activities and to ensure protection to the helpless patients. But the scenario in India is far from satisfactory. The Organ Transplantation Act 1994 applies only to few States and even in those States there is no machinery to ensure absence of abuse of discretion by the administrative agencies. The result is that many valuable lives, which could have been saved, are lost due to the carelessness and lack of interest by the authorities concerned.

(C). Access to Medical Records

Rights to Self determination of an individual extend to his freedom to decide whether to undergo a medical treatment or not. A rational decision in this regard can be taken only if all the information necessary for taking a decision is available to him. This is recognized as part of human rights by all civilized States and also as a part of right to information. The method adopted is to insist on informed consent of the patient. Similar is the case with information relating to his past illness, diagnosis and treatment given by a health authority and all matters, connected with treatment procedures. In Gaskin v United Kingdom105 the European Human Rights Commission observed that access to medical information and record is an essential right of a person to know about his family history and developments during childhood. Failure to supply such information, according to the Commission would result in violation of

104       Section 14 of Organ Transplantation Act
the human rights of the individual in all aspects. In the United Kingdom as well as the United States access to medical information is recognized by statutes.

In England, the Data Protection Act, 1987 and the Access to Medical Information Act, 1991, direct the health authorities, to divulge information contained in the health records except in exceptional cases. Whether the information is required for further medical purpose or for litigation regarding deficiency in medical services is not material. But in India the Consumer Courts have taken a different view. In *Poonam Medical Foundation Case*, 106 the National Consumer Commission has taken the view that, in the absence of statutory or contractual right, the patient cannot claim access to medical records. An opposite view could have been taken by invoking the principle of right to life. Failure to recognize it will amount to violation of human rights. However disclosure of medical information to third parties may involve breach of confidentiality on part of health authority. Such disclosure is required to protect the public from contagious diseases or to prevent greater harm to the other members of the public. Thus in the case of outbreak of contagious diseases, a medical officer is bound to disclose such information.

In *Dr. Tokudha Yepthomi v Apollo Hospital Enterprises Limited*, 107 the apex Court of India, without considering the human right issues involved, refused to look into the problem of breach of confidentiality in divulging HIV+ status. These are the areas involving blatant human right violations related to medical malpractice and must be considered seriously while enacting legislation.

**D) Safety of products used in health Care**

An important aspect in the medical service sector is the quality, safety and prices of products used in medical treatments. Substantial injury may arise as a result of

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106 (1995) 1 CPJ. 232 (N.C.)
107 (1998) 7 SCC. 626.
prescription of hazardous medicine. Many reported instances show that prescription of hazardous medicine caused havoc to the public. In *A.S. Mittal v. Union of India*¹⁰⁸ and *Sunil Blood Bank Case*,¹⁰⁹ Court imposed liability on hospital authority. The problem related to hazardous drugs was considered by the Apex Court in *Vincent Panikulangara v. Union of India*¹¹⁰ and *Common cause v. Union of India*.¹¹¹ It gave many directions for proper prescription and also effective functioning of blood banks in India. In European countries the wrongful prescription of hazardous medicine is considered as violation of human Rights of the people. The European Human Rights Court held that supply of blood containing HIV positive virus and the failure of the State to award compensation to the victims amounted to human rights violation.¹¹²

**(E) Experimental medicine and clinical trials**

Experimentation of medicine in human body is a blatant violation of Human Rights. The Geneva Convention on Human Rights and Biomedicine 1998 provides many safeguards relating to this procedure. Countries like the United States have adopted detailed procedural safeguards relating to clinical trials and experimentation. These Guidelines and rules deal with permissibility and condition for human trials and the norms for promoting human rights of the clinical subjects. It is felt that absence of proper control on experimental medicines and ethical trials cause gross violation of Human rights. This is also another area of medical malpractice, which infringes human rights of people.

¹⁰⁸ (1989) 3 SCC. 223.
¹¹⁰ Supra n 40
¹¹¹ AIR 1987, 1987 SCR (1) 497
(F) Abuse of Diagnostic and Curative Procedure

While the breakthrough in medical science was helped to promote health of people, the abuse of those very procedures can lead to disastrous consequence. For example, the pre-natal diagnostic technique is often used to determine the sex of the unborn child and has also helped in detecting early disorders in the foetus; but at the same time it has triggered off female foeticide. Similarly, organ transplantation which is boon to several people has also evoked instances of theft of vital human organs like kidney.

However the pre-Natal Diagnostic Techniques (Prevention of Misuse) Act, 1994 and the Human Organ Transplantation Act, 1994 have very limited application for preventing this medical malpractice. There are many reported incidents where persons of sound mind are confined to a mental hospital because of the involvement of some doctors. The provisions of the Mental Health Act, 1986 have not been able to tackle these malpractice. But at the same time in European countries, compulsory detention of patients in mental hospital and failure to review the detention periodically is treated as violation of Human rights.

Elaborate provisions have been made in the European Convention of Human Rights and Biomedicine to control abuse of human Organ transplantation. Any experimentation on human embryo is strictly regulated in England by the Human Fertilization and Embryology Act, 1991. It is felt that absence of a clear understanding of the potential harm resulting from these procedures made India a silent spectator to these issues. Absence of proper and effective legislative control in these areas may result in misuse of the new technologies by the practitioner leading to rampant human right violation. Thus in Brugganmann & Schecoton v. Germany113 the European Commission on Human Rights held that failure to consult the father before abortion is a violation of human rights of the father.

113 (1981) 8 E.H.R.R.244.
A similar conflict may arise in recognizing a biological father as the legal father of child. The modern reproductive technique often involves misrepresentation and malpractice by physician for money. So many concealed techniques are used by the doctors for the success of artificial insemination that is unknown for the spouses. That may be the reason why, the European Human Right Commission refused to accept all unethical practices as a matter of right of doctors and held them as gross Human Right violations.\textsuperscript{114}

The patient’s health is a major priority on the political agenda of the leading political parties. Position in European countries is far better than India. It is a well known fact that litigation and complaints in health care have increased over the last 10 years.\textsuperscript{115} The National Audit office stated that: reported liabilities of clinical negligence continues to increase with the NHS with total potential liabilities of $ 2.4 billion disclosed in the accounts at 31 March 2001, an increase of 20-60 billion.\textsuperscript{116} Every year the Health Service Ombudsman reported rises in complaint to his office,\textsuperscript{117} even though U.K has effective medical laws.

Medical law in Australia is a morass of statutory enactments and judge –made law. It may only readily be understood when placed in its context. Medical law operates within the federal structure of the Australian State. Each level of Government in Australia (whether local, State, or Federal) has legislative responsibility for different type of health care.\textsuperscript{118} So in Australia they have effective legislation for preventing or controlling medical offence and negligence.

\begin{itemize}
\item \textsuperscript{114} (1981) 3 E.H.R.R. 409
\item \textsuperscript{115} Karoon v. Netherlands (1995) 14 E.H.R.R 263
\item \textsuperscript{117} Prof. Robyn Martin and Linda Johnson, \textit{Health Service Ombudsman for England, Australian Medical Law}, London, Cavendish Publishing Co.Ltd , 2000, p.200
\item \textsuperscript{118} Brazier M. and Glover N, Does Medical Law have a future, \textit{Journal of Medical Ethics}, Vol.5,2001.
\end{itemize}
Historically, patients have relied on the advice of their medical providers. If any question was asked it was assumed that the doctor was the expert and knew what was best for the patient. Although the majority of health care providers are competent professionals with the utmost concern for the well-being of their patient, medical mistake do occur. And, unfortunately, due to the negligence of health care providers, the medical profession has come under attack in accounts of horrendous medical mistake. Statistics demonstrate that between 44,000 and 88,000 hospital patients die each year as a result of medical negligence.\textsuperscript{119} This is the position of medical malpractice in western countries where effective law and maximum health facilities are easily available.

The study of health law as an identifiable academic discipline across EU, is a relatively recent development\textsuperscript{120}. Some academic commentators have cast the discipline in term of Medical Law which was clearly reflective of the dominance of the clinician in the litigation process. Medical care law may be seen generally as a composite of principles derived from other legal discipline such as standard principles of Criminal laws (applicable in malpractices litigation).\textsuperscript{121} There is also increasing trend across member States to enact specific laws that relate to medical care. Moreover there is some evidence that medical law in the member States of the EU is being fundamentally affected by one major ethical work which has been legitimatized through legal developments, that of human rights analysis.


\textsuperscript{121} Ibid.
Conclusion

It is high time in India makes effective legal machinery to prevent medical malpractices by the doctors intentionally or under the title of negligence. They committed all these evil things either as a racket or as a single person for money and some other personal achievements. These manipulations can be controlled only through the hands of proper, effective and skilled legal machinery, otherwise the medical practitioners will create confidence and outstanding courage to do whatever they like. Medical practitioner, hospitals have been committing human right violation on a daily basis with little or masses. They have assured “god like” disposition to do anything including depriving people of their basic right to health care. Hence there is a need for codified law with meaningful provisions for balancing the interest of medical practitioners, hospital authorities and patients effectively.