CHAPTER-IV

ROLE OF JUDICIARY AND RIGHT TO HEALTH
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4.1. Introduction

A legal system's efficacy depends much upon functional competence of its procedural law and the dynamism of its grievance redressing institutions like Judiciary. Remedial Law's support to substantive rights and reformatory principles is so significant that it is the availability of remedy that makes a right meaningful. The effort of the legislation would become successful only if the remedial institutions, mechanisms and procedures evolved by the system also support the benevolent aim. Thus from the dawn of civilization to the present day, legal systems have been experimenting in refining the Justice delivery system to make the laws more popular, accessible, prompt and effective. In addition to the progressive Judiciary, the Constitution provide for amendments to accommodate themselves to the changing social and economic circumstances.

Thus the Judiciary, legislative and the Constitution have great supportive contributions to make consumer education relating to health more effective. With the recognition that both the Indian Constitution and the fundamental right of life emphasize human dignity, began to address the importance of health to Indian citizen. In the Directive Principles of State Policy, Article 47 declares that the State shall regard the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties. Since the Directive Principles of State Policy are not enforceable by the Court, implementation of the guarantee has remained illusory. However, in a series of cases dealing with the substantive content of the right to life, the Court has found that the

228 Bandhua Mukti Morcha A.I.R. 1984 SC 812
right live with human dignity including right to good health.\textsuperscript{229} The right to health was an integral factor of a meaningful right to life. The Court held that the right to health and medical care is a fundamental right under Article 21.\textsuperscript{230} The Supreme Court, while examining the issue of the Constitutional right to health care under arts 21, 41 and 47 of the Constitution of India, observed that the right of one person correlates to a duty upon another, individual, employer, Government or authority.\textsuperscript{231} Hence, the right of a citizen to live under art 21 casts and obligation on the State. This obligation is further reinforced under art 47; it is for the State to secure health to its citizens as its primary duty. No doubt the Government is rendering this obligation by opening Government hospitals and health centers, but to be meaningful, they must be within the reach of its people, and of sufficient liquid quality. Since it is one of the most sacrosanct and valuable rights of a citizen, and an equally sacrosanct and sacred obligation of the State, every citizen of this welfare State looks towards the State to perform this obligation with top priority, including by way of allocation of sufficient funds. This in turn will not only secure the rights of its citizens to their satisfaction, but will benefit the State in achieving its social, political and economic goals.

Human being, who is classified as an animal by the science, but due to his peculiar characteristics and tremendous power of reasoning later on proved himself to be different from mere animal and get treated as a social animal. Day by day human being get armed with advanced scientific technology and knowledge. He made qualitative as well as quantitative efforts to achieve better quality of life by utilizing natural resources, at the time of doing this he never realized the unprecedented and ever increasing hazards, which he is facing today. The excessive exploitation of natural resources and there imprudent use rather misuse have unfortunately led to serious ecological crises which now

\textsuperscript{229} Ibid, at-811
\textsuperscript{230} Consumer Education and Research Center Vs. UOI
\textsuperscript{231} State of Punjab Vs. Ram Lubhaya Bagga
brought the human health in danger. Therefore activities of man and state are not only posing serious threat to the ecosystem but also the existence of entire human race, including future generations. The right to health of human being at large and effort made by legislature to protect the said right as well as certain shortcomings in respect of advance scientific technology and its proper regulation. As the present paper emphasis on right to health therefore it is necessary to discuss the concept of right from the jurisprudential point of view. Prof. Roscoe pound in his theory of social engineering defined right as an interest recognized, protected and enforced by law, the whole theme of social engineering theory revolves around the protection and enforcement of right. Therefore right to health is nothing but the interest of human being which must have to be recognized, protected and enforced by the legal system therefore legal system have to make suitable environment, which would recognize the right relating to health and ensure protection of it and if there is violation of it then must enforce such right on the petition of aggrieved person.

Now it is essential to know about the right to health and its regulation by the law, there are several questions pertaining to this such as by which Act or Statute the right to health was conferred? Constitution of India is public law, which governed the relationship between state and its citizens. To achieve the goals set out in the preamble of the constitution it confers certain rights upon the people imposes duties upon the citizens, and issued certain directives to the state. From the perspective of the right to health, following constitutional provisions carries an importance. The Supreme Court has asserted that in order to treat a right as a fundamental right it is not necessary that it should be expressed in the constitution as a fundamental. Political social an economic changes in the country entail the recognition of new rights. The law is its eternal youth grows to meet the demands of the society. Similarly right to

232 C.f. Indian Environment Law & Role of Judiciary: Dr Krushna Chandra sena (SCJ 2008) 852
233 Prof. Roscoe pound: Jurisprudence. Vol-3 west publishing company 1959
health is also one of the rights, which is derived from right to life and personal liberty as granted by constitution. The right to health as extended under Article 21 is relates with occupational accidents and diseases remains the most appealing human tragedy of modern industry. Health hazards faced by the workers in the asbestos factories were brought to the attention of the Supreme Court in C.E.R.C. V. Union of India.\textsuperscript{235} The court held that right to health, medical aid to protect the health and vigor of a worked while is service or post-retirement is a fundamental right under article 21. One another crucial question relating to medical care and health was arose in Mr. X. V. Hospital Z\textsuperscript{236} the question before the court was can a doctor disclose to the would be wife (with whom the marriage is contracted) of a person that he is HIV positive or does it violate the right to privacy of the person concerned. The court answered both the question is negative court stated that the lady proposing to marry such a person is also entitled to all the human right which are available to any human being, therefore it include the right to be told that a person with whom she was proposed to be married, was the victim of a deadly disease which was sexually communicable.

The Indian Constitution, promulgated in 1947, a creature of its age and on its face is far less progressive than its South African counterpart operating from the mid 1990s. Economic and social rights, including the right to health contained in Article 47 of the Indian Constitution\textsuperscript{237} are consigned to the Directive Principles of State Policy (DPSP) Section which, according to Article 37 of the Constitution, “shall not be enforceable by any Court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws.”

\textsuperscript{235} AIR 1995 SC 992
\textsuperscript{236} AIR 1999 SC 495
\textsuperscript{237} Article 47 provides: ‘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 endeavor to bring about prohibition of the consumption except for medicinal purpose of intoxicating drinks and of drugs which are injurious to health.'
Therefore on its face, the Supreme Court of India is barred from considering and enforcing individual health rights claims; but rather it is concerned with offering non-binding guidelines on how health policies should be implemented, whilst leaving the final decision to the State. However, the early 1970s witnessed a watershed in Indian human rights litigation with the Fundamental Rights Case\textsuperscript{238}. This case ushered in an unprecedented period of progressive jurisprudence, following the recognition by the Court that the Directive Principles of State Policy should enjoy the same status as "traditional" fundamental rights. At the same time, rules on standing were relaxed in order to promote public interest litigation and access to justice through the writ petitions that could be submitted on a postcard\textsuperscript{239}.

4.2. Right to Health Care as a Fundamental Right

In the Fundamental Rights, Part III, of our Constitution does not provide directly any provision relating to Right to Health. However, the Supreme Court, while widening the scope of art 21 and the Government's 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. The Government discharges this obligation by providing medical care to the persons seeking to avail of those facilities\textsuperscript{240}. Article 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 hospitals run by the State are duty bound to extend medical assistance for preserving human life. Failure on the part of a Government

\textsuperscript{238} Keshavananda Bharati v. State of Kerala (1973) 4SCC 225.
\textsuperscript{239} For a good overview of the Indian courts' approach to economic, social and cultural rights see S. Muralidhar, 'Justiciability of Economic and Social Rights: The Indian Experience' in Circle of Rights (Washington D. C.: International Human Rights Internship Program, 2000).
\textsuperscript{240} Paschim Banga Khet mazdoor Samity and ors Vs. State of West Bengal and ors(1996) 4 SCC 37
hospital to provide timely medical treatment to a person in need of such treatment, results in violation of his right to life guaranteed under Article 21. The Court made certain additional directions in respect of serious medical cases:

- Adequate facilities are provided at the public health centers where the patient can be given basic treatment and his condition stabilized.
- Hospitals at the district and sub divisional level should be upgraded so that serious cases are treated there.
- Facilities are given for specialist treatment which should be increased having regard to the growing needs and it must be made available at the district and sub divisional level hospitals.
- In order to ensure availability of bed in any emergency at State level hospitals, there should be a centralized communication system so that the patient can be sent immediately to the hospital where bed is available in respect of the treatment, which is required.
- Proper arrangement of ambulance should be made for transport of a patient from the public health center to the State hospital.
- Ambulance should be adequately provided with necessary equipments and medical personnel\(^{241}\).

The Supreme Court in its landmark judgment ruled that every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life. No law or State action can intervene to avoid delay, and the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute, and paramount, laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained, and must, therefore, give way\(^{242}\). The Court

\(^{241}\) Ibid. em, at 47-48
\(^{242}\) Paramanand Katara Vs. Union of India A.I.R. 1989 SC 2039
laid down the following guidelines for doctors, when an injured person approaches them:

➢ Duty of a doctor when an injured person approaches him: Whenever, on such occasions, a man of the medical profession is approached by an injured person, and if he finds that whatever assistance he could give is not really sufficient to save the life of the person, but some better assistance is necessary, it is the duty of the man in the medical profession so approached to render all the help which he could, and also see that the person reaches the proper expert as early as possible.

➢ Legal protection to doctors treating injured persons: A doctor does not contravene the law of the land by proceeding to treat an injured victim on his appearance before him, either by himself or with others. Zonal regulations and classifications cannot operate as fetters in the discharge of the obligation, even if the victim is sent elsewhere under local rules, and regardless of the involvement of police. The 1985 decision of the Standing Committee on Forensic Medicine is the effective guideline.

➢ No legal bar on doctors from attending to the injured persons: There is no legal impediment for a medical professional, when he is called upon or requested to attend to an injured person needing his medical assistance immediately. The effort to save the person should be the top priority, not only of the medical professional, but even of the police or any other citizen who happens to be connected with the matter, or who happens to notice such an incident or a situation.

The Supreme Court has recognized the rights of the workers and their right to basic health facilities under the Constitution, as well as under the international conventions to which India is a party. In its path breaking
judgment, the Court delineated the scope of art 21 of the Constitution, and held that it is the fundamental right of every one in this country, assured under the interpretation given to art 21 by this Court in Francis Mullin's Case to live with human dignity, free from exploitation. This right to live with human dignity enshrined in art 21 derives its life breath from the Directive Principles of State Policy and particularly clause (e) and (f) of art 39 and arts 41 and 42. It must include protection of the health and strength of workers, men and women; and children of tender age against abuse; opportunities and facilities for children to develop in a healthy manner and in conditions of freedom and dignity; educational facilities; just and humane conditions of work and maternity relief. These are the minimum requirements, which must exist in order to enable a person to live with human dignity. No State, neither the central Government nor any State Government, has the right to take any action which will deprive a person of the enjoyment of these basic essentials.

The health and strength of a worker is an integral facet of the right to life. The aim of fundamental rights is to create an egalitarian society to free all citizens from coercion or restrictions by society and to make liberty available for all. The Court, while reiterating its stand for providing health facilities, held that a healthy body is the very foundation for all human activities. That is why the adage 'Sariramadyam khalu dharma sadhanam'. In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health. Public interest litigation brought under article 32 of the constitutions and the allied negligence on the part of the doctors in a free eye care camp at Khurja. However, laudable the intentions with which it might it have been launched. The operated eyes of the patient were

242 A.I.R. 1984 SC 812
243 Bandhua Mukti Morcha Vs. Union of India A.I.R. 1984 SC 812
244 CESE Ltd Vs. Subhash Chandra Bose
irreversibly damaged owing to post-operative infection. The mishap was due to some common contaminated source. After an inquiry it was found that it was due to normal saline used in the eyes at the time of the operation. The vision of 84 persons could not be restored. The Court held that a mistake by a medical practitioner, which no reasonably competent and careful practitioner would have committed, is a negligent one. The Court further held that the highest standard of aseptic and sterile should be maintained. The govt. spends so much on public health but standard of cleanliness and hygiene are to be desired. The victims were given a compensation of Rs 5000 as interim relief. The State govt. was directed to pay a sum of Rs. 12,500 to each of the victims. Similarly a free eye camp was organized by lions club and some social service organizations on 28th and 29th January 1988. In this camp free eye treatment were given and 151 people were operated for cataract problem. Most people who got operated in this eye camp developed eye infection and severe eye pain. 72 of them lost the sight on one eye while 4 of them lost sight of both the eyes.

The Supreme Court relied on international instruments and concluded that right to health is a fundamental right. It went further and observed that health is not merely absence of sickness: “The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. Facilities of health and medical care generate devotion and dedication to give the workers’ best, physically as well as mentally, in productivity. It enables the worker to enjoy the fruit of his labour, to keep him physically fit and mentally alert for leading a successful economic, social and cultural life. The medical facilities are, therefore, part of social security and like gilt edged security, it would yield immediate return in the increased production or at any rate reduce

248 Pushpaleela Vs. State of Karnataka
249 CESC Ltd. Vs. Subash Chandra Bose A.I.R. 1992 SC 573,585

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absenteeism on grounds of sickness, etc. Environmental pollution is linked to Health and is violation of right to life with dignity: In *T. Ramakrishna Rao Vs. Hyderabad Development Authority*, the Andhra Pradesh High Court observed: Protection of the environment is not only the duty of the citizens but also the obligation of the State and it’s all other organs including the Courts. The enjoyment of life and its attainment and fulfillment guaranteed by Article 21 of the Constitution embraces the protection and preservation of nature’s gift without which life cannot be enjoyed fruitfully. The slow poisoning of the atmosphere caused by the environmental pollution and spoliation should be regarded as amounting to violation of Article 21 of the Constitution of India²⁵⁰.

It is therefore the legitimate duty of the Courts as the enforcing organs of the constitutional objectives to forbid all actions of the State and the citizens from upsetting the ecological and environmental balance²⁵¹. The Supreme Court held that environmental, ecological, air and water pollution, etc., should be regarded as amounting to violation of right to health guaranteed by Article 21 of the Constitution. It is right to state that hygienic environment is an integral facet of the right to healthy life and it would not be possible to live with human dignity without a humane and healthy environment²⁵². The Supreme Court held that right to health and medical care is a fundamental right under Article 21 read with Article 39(e), 41 and 43²⁵³. In *Subhash Kumar Vs. State of Bihar²⁵⁴*, the Supreme Court held that right to pollution-free water and air is an enforceable fundamental right guaranteed under Article 21. Our Constitution makers

²⁵¹ T. Damodar Rao and others Vs. Special Officer, Municipal Corporation of Hyderabad A.I.R. 1987 AP 171
²⁵³ Consumer Education and Research Centre Vs. Union of India, Kirloskar Brothers Ltd. Vs. Employees’ State Insurance Corporation,
was much aware about the public health or right to health that's why they imposed liability on State by some provision (Article 38, 39(e) 41, 42, 47, 48A) of the Directive Principles of State Policy. Constitution makers included public health in the Directive Principles of State Policy because they were well-known about it that only inclusion of right to health as fundamental rights will give only right but it will not ensure medical facilities. If right to health included as a fundamental right then what happened it is clear that State can protect itself to say that who is going to take away your right for example if any person affected by T.B. defended for his right to health as a fundamental right, Then State can protect to say that go and be healthy T.B. is not caused to you by State. Thus right to health as fundamental right cannot be given remedy for ill person. For treatment of T.B. there are so many component that are in requirement i.e. Hospital, doctor and medicine. So Constitution makers included it in the Directive Principles of State Policy for to impose duty to State so that State will protect and improve public health.

Due to this duty State is taking steps in this regard and hospitals are running in control of State to give free health service to public at large. There is no need of right to health for a person to be healthy. A person should have health entitlements, medical aid, medical assistance which provided are by States. Right to health and right to education are similar. Right to education was not fundamental right at the time of Constitution drafting. It was also to inform of the Directive Principles of State Policy because for education there is a need of schools and it will be made by State itself. How in the State of Kerala before right to education there was 100% literacy. Because State Government of Kerala provided entitlements for education and realized its duty and achieved it by taking necessary steps in this regard.
In *Dr. A.S. Chandra Vs. Union of India*\(^{255}\), the Andhra Pradesh High Court observed that private hospitals or private medical practitioners provide services for a consideration, that is, for a fee. Hence, their service will be considered as 'service' for the purposes of *Section 2*(1) (o) of the Act. Similarly, patients who avail these services will be considered as consumers. The exact opposite view was expressed by a Division Bench of the Madras High Court\(^ {256}\).

Some judgments passed by the NCDRC created further confusion. In its judgment and order dated 15 December 1989 in First Appeal No. 2 of 1989, the Commission held that persons who avail treatment at hospitals run by the Government are not 'consumers'. It was further held that treatment received at Government hospitals cannot be regarded as service 'hired' for 'consideration'\(^ {257}\). In *Cosmopolitan Hospitals and Another Vs. Sinl Vasantha P. Nair*\(^ {258}\) it is observed that medical services provided on payment constitute service as per the Consumer Protection Act, 1986. Some judgments by the various SCDRCs led to more confusion. Rajasthan SCDRC was that medical services in a Government run hospital cannot be considered as service under the Consumer Protection Act, 1986.

### 4.3. Medical Negligence

All the confusions regarding the scope of the Consumer Protection Act, 1986 regarding medical negligence cases were cleared by the Supreme Court of India in its landmark judgment of the JAM case\(^ {259}\). It will be helpful at this stage to examine some relevant *Sections* of the Consumer Protection Act, 1986 and their interpretation by the Apex Court in that case.

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\(^ {255}\) *(1992)1 Andhra Law Times 713.*  
\(^ {257}\) *As quoted in the IMA case*  
\(^ {258}\) *1 (1992) CPJ 302 (NCDRC).*  
\(^ {259}\) *A.I.R. 1996 SC 550.*
The growth of private healthcare sector has been largely seen as a boon, however it adds to ever-increasing social dichotomy. The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards predominantly urban, tertiary levels health services with profitability overriding equality, and rationality of care compromised. The increasing cost of healthcare that is paid by 'out of pocket' payments is making healthcare unaffordable for a growing number of people. One in three people who need hospitalization and is paying out of pocket is forced to borrow money or sell assets to cover expenses. Over 20 million Indians are pushed below the poverty line every year because of the effect of out of pocket spending on health care. In the absence of an effective regulatory authority over the private healthcare sector the quality of medical care has deteriorated.

A recent World Bank report acknowledges the facts that doctors over-prescribe drugs recommend unnecessary investigations and treatment and fail to provide appropriate information for patients even in private healthcare sector. The same report also states the relation between quality and price that exists in the private healthcare system. The services offered at a very high price are excellent but are unaffordable for a common man. Effects of socio and economic inequality on health of a society are profound. In a large, overpopulated country like India with its complex social architecture and economic extremes, the effect on health system is multifold. Unequal distribution of resources is a reflection of this inequality and adversely affects the health of under-privileged population. The socially under-privileged are unable to access the healthcare due to geographical, social, economic or gender related barriers. Market savvy but unregulated private healthcare sector, weak insurance systems and lack of healthcare financing make the gap between the rich and the poor more apparent.
4.3.1. Private health care

Indian healthcare infrastructure has evolved over the past six decades after the Indian independence. The role of private sector has been critical in the provision of medical care services. Though public sector provisions dominated healthcare delivery for the first few decades, economic and political changes over the past few decades, propelled, the growth of private sector, which is now poised to grow substantially. Other factors which have aided the Private sector in dominating the Indian healthcare delivery market include changing consumer perception, increasing awareness about quality of medical care, greater penetration of insurance, increased purchasing power, changing demographic structure, etc. Though, the debate over the 'righteousness' in the change in orientation in the Indian healthcare system continues\textsuperscript{260}, various Government policy initiatives are directed towards enhancing private sector investment in healthcare. Private sector, itself has undergone tremendous changes over the decades.

The advent of corporate culture in healthcare delivery has been observed in the past two decades, as healthcare was viewed as a profitable venture. Professional management of healthcare institutions, to generate profits or surplus also gained considerable momentum over the past two decades. Recent innovations include focus on ambulatory and retail healthcare, designed to focus on non communicable diseases. Inherent factors like improved efficiency, better quality, greater reliability and transparency have also aided in the growth of private sector in healthcare. With the incorporation of medical professionals under the Consumer Protection Act, 1986, there was increased realization of the importance of quality in provision of medical care services. With various initiatives of the Quality Council of India, efforts are underway to promote standardization of medical care services and enhance quality of medical care provided by the private sector. Private sector holds to key to improving

\textsuperscript{260} Nadkarni, 2010
healthcare delivery in India. However, as private sector continues to explore the opportunities, a tradeoff between ‘social welfare’ and ‘business orientation’ is critical. Further quality needs to standardize in a highly fragmented healthcare delivery system of India.

The private sector plays an important role in India's health care delivery system. Through a wide network of health care facilities, this sector caters to the needs of both urban and rural population and has expanded widely to meet increasing demands. Utilization patterns indicate that health care seekers depend highly on the private sector. Despite the widespread public infrastructure, a higher proportion of health services are provided by the private sector than by Government facilities. The private health care sector has grown significantly over time. The growth of this sector has been further triggered by a number of factors, including a liberalized economic policy, rapid influx of medical technology, growing deficits of public sector hospitals, and a rising middle income class. Its growth has profound implications for the existing character of the Indian health care system and its future course. Recent studies indicate that private health care significantly affects both the cost and quality of available health care services in India. Although cases of superfluous and high cost of services rendered by private physicians and hospitals have been reported, there is no evidence that these result in any greater use of public facilities.

Significantly, despite the problems resulting from the growth of the private sector, there has been little effort to draw up appropriate market or regulatory mechanisms to ensure its desirable growth. This is unfortunate since it is well known that leaving the health care to the market forces does not necessarily lead to an effective and efficient health care system. The role of the State and self-regulatory bodies is important in minimizing the unintended and undesirable consequences emerging from the growth of the private sector. At some point of time it becomes imperative for the stakeholders to address the issues of equity, efficiency and quality of care in this sector. The structure of
the health care system in India is complex and it includes various types of providers. These providers practice in different systems of medicines and facilities. The providers and facilities in India can be broadly classified by using three dimensions: ownership styles (public, not-for-profit, and for-profit); systems of medicine (allopathic, homeopathic, and traditional); and types of organization (hospitals, dispensaries, and clinics). These dimensions are interdependent and overlapping in nature. Using the ownership criterion, the health care system can be divided into four broad sectors:

- The public sector, including Government-run hospitals, dispensaries, clinics, primary health care centers and sub-centers, and paramedics;
- The not-for-profit sector, including voluntary health programs, charitable institutions, missions, churches, and trusts;
- The organized private sector, including general practitioners (having at least a bachelor's degree or equivalent in medicine), private hospitals and small private hospitals (popularly known as nursing homes), registered medical practitioners, dispensaries and other licensed practitioners; and
- The private informal sector, including practitioners not having any formal qualifications (e.g., faith healers, herbalists, priests, tantriks, hakims, and vaidyas).

Improving public health for all is documented in the Constitution of India as one of the primary duties of the State. To achieve this, the planning process of the country provides a broad framework to the states to develop their health services infrastructure, as well as facilities for medical education and research. Since the inception of the planning process, the State and central Governments have experienced a number of constraints in implementing the health programs effectively. In 1982, the National Health Policy (NHP) acknowledged these constraints and suggested an integrated and comprehensive approach towards the future development of health care services. To mitigate
the problem of limited resources, the policy document recommended that the States design processes to encourage the practice by private medical professionals and investment by non-Government agencies in establishing curative centers. States were also encouraged to provide organized, logistical, financial and technical support to voluntary agencies active in the health field. The policy thrust of NHP in promoting the private and voluntary health curative services has been one important step towards providing clear direction to the States. These directions were supposed to help the State Governments develop their own strategies to utilize untapped resources and strengthen their ability to meet the growing health needs of people.

4.3.2. Consumer Health Rights

According to Section 2 (1)(b) of the Consumer Protection Act, 1986, the term 'complainant' means, A consumer; or Any voluntary consumer association registered under the Companies Act, 1956 (I of1956) (H under any other law for the time being in force; or The Central Government or any State Government, One or more consumers, where there are numerous consumers having the same interest; In case of death of a consumer, his legal heir or representative, who or which makes a complaint. When a patient, who is aggrieved because of negligent treatment or deficiency of service provided by a physician or health care provider, lodges a complaint in writing for claiming compensation, he becomes a complainant. Similarly, the legal heirs of a patient, parents of a minor patient, or a consumer organization can become complainants by lodging a written complaint. Supreme Court observed the expression 'complaint' as defined in Section 2(1) (b), is comprehensive to enable the consumer as well as any voluntary consumer association registered under the Companies Act, 1956 or under any other law for the time being in force, or the Central Government or any State Government or one or more consumers where
there are numerous consumers having the same interest, to file a complaint before the appropriate Consumer Disputes Redressal Agency\textsuperscript{261}.

4.4. Medical Negligence under Civil Laws

Negligence in legal words means the breach of a legal duty. In other words, it is carelessness revealed in matters in which carefulness is compulsory by the law. Negligence gives right to patients to initiate action against such act. 'Implied Undertaking' is the duty of every person who offers medical advice and treatment, which consists of decision to take a case, its treatment and to administrate the same\textsuperscript{262}. But doctors are not liable for their treatment, if they do not charge fees as per the term SERVICES defined in Section 2(1) of Consumer Protection Act, 1986\textsuperscript{[6]}. A doctor can be held liable for negligence only if the plaintiff can give enough evidence that defendant is guilty of a failure that no other doctor with ordinary skills would have done with reasonable care. Certain conditions must be satisfied before liability can be considered. Expert opinion and evidence from medical science can be used best to prove the allegation.

4.4.1. The Common Law Principles and Judicial Decisions

The history of the development of tort\textsuperscript{1} litigation, especially with regard to medical negligence cases, is of recent origin in India. It has its roots in the English common law i.e., where there is a right there is a remedy. Its transplantation in India by Courts, to exercise their power to administer law according to 'justice, equity and good conscience' indicate that torts are primarily those wrongs for which either statutory remedies are not available or, if available, are inadequate or inappropriate. Further, in formulating the concept of actionable wrong, Courts are in fact not only identifying the interests which require protection but also the circumstances under which they need to be

\textsuperscript{261} Ibid, para. 10
\textsuperscript{262} Laxman Balkrishna Joshi Vs. Trimbak Bapu Godbole (MANU/SC/0362/1068)
protected. With changes in social, political and economic conditions, there are inevitable changes in the nature and extent of the protected interests. Finally, the interests are preserved and promoted through the grant of a civil right of action for unliquidated damages to the aggrieved. Sir John Salmond defined 'tort' as 'a civil wrong for which the remedy is an action for damages, and which is not exclusively the breach of a contract or breach of a trust or other merely equitable obligation'. With the passage of time and to meet the emerging situations and demands the legislature in UK has resorted to enactment of legislations such as;

- The Fatal Accidents Acts 1846, 1959, 1976,
- The Workmen's Compensation Act 1897,
- Law Reform (Miscellaneous Provisions) Acts 934 and 1971,
- Law Reform (Contributory Negligence) Act 1945,
- Crown Proceedings Act 1947, Defamation Act 1952,
- Law Reform (Husband and Wife) Act 1962,
- Congenital Pisabilines (Civil Liability) Act 1976,
- Unfair Contract Terms Act 1977,
- Civil Liability Contribution Act 1978 and
- Consumer Safety Act 1978 etc.

Further, in a tort of medical negligence, the cause of action is personal against the person who has been negligent in discharging his duties, and that the cause of action does not survive against his estate or the legal representative. There has been steady growth of tort litigation in India in the area of medical negligence. This is primarily due to lack of awareness about one's own rights, the spirit of tolerance, the expenses involved and the delay in disposal of cases in Civil Courts etc.

263 Balbir Sing Makol Vs. Chairman. M/s Sir Canea Ram Hospital & om (2001)
4.4.2. Deficiency in Legal System

The legal system, i.e. the Consumer Protection Act, 1986 has certain deficiencies. Some of the provisions of the Act required to be amended to improve the system and provision of law for giving reasonable justice to the consumers.

- Under Consumer Protection Act, 1986, the definition of terms such as Service, Consumer etc. are unclear and have very thin relevance to medical negligence. It lacks terminology too hence can lead to confusion during trials in consumer forums.\(^{264}\)

- It also lacks the provision for a general physician being into the commission, as it is nowhere mentioned in the composition of district, State and national dispute redressal commissions. This can lead to unfair judgment, as the commission has no primary knowledge of medicine.

- The right to refuse to attend a patient granted to doctors can be detrimental in the cases of emergency. Generally no medical professional or physician will claim such rights but there can be an exceptional cases where doctors do refuse and its contrary to article 21, right to life and personal liberty which implies right to healthcare\(^{265}\).

- Fake complaint or lawsuit can be filed under Consumer Protection Act, 1986, causing serious harm to the reputation of doctors.

- The personal influence of doctors, if released on bail can affect the proceeding in Court under criminal negligence and can lead to tempering of evidences and further conclude to injustice.

- The investigating officer and the private complainant cannot always be supposed to have knowledge of medical science so as to determine whether the act of the accused medical professional amounts to rash or negligent act within the domain areas of criminal law under Section 304-A of IPC.

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\(^{264}\) Consumer Protection Act, 1986

\(^{265}\) Parmananda Katara Vs. Union of India (AIR 1989 SC 2039)
Under Article 21 of Indian Constitution, right to health care is a right granted to each and every citizen as well as non-citizens. It is quite contrary to right to refuse to attend a patient, granted to doctors. The Supreme Court held that right to refuse to attend a patient is a right of every doctor but cannot be claimed in whatsoever emergency state. If a doctor does so, it is considered as a breach to legal duty, an essential element of negligence. Right to health care is also declared as Human Right in Article 25(2) of UDHR and Article 7(b) of International Covenants on Economic, Social and Cultural Rights. In all, it is clear that state is bound with the responsibility to protect the citizens against the evil, but it is not always that the doctors are at fault. Medical professions being noble profession of all, doctors are always provided with the high magnitude of reverence and there cannot be any intention involved to kill or injure any person. There is definitely need for new accurate guidelines and specified laws. After the Consumer Protection Act, 1986, came into effect, a number of patients have filed cases against doctors. This article presents a summary of legal decisions related to medical negligence: what constitutes negligence in civil and criminal law, and what is required to prove it. Public awareness of medical negligence in India is growing.

Hospital managements are increasingly facing complaints regarding the facilities, standards of professional competence, and the appropriateness of their therapeutic and diagnostic methods. After the Consumer Protection Act, 1986, has come into force some patients have filed legal cases against doctors, have established that the doctors were negligent in their medical service, and have claimed and received compensation. As a result, a number of legal decisions have been made on what constitutes negligence and what is required to prove it.

4.4.3. Negligence

Negligence is the breach of a legal duty to care. It means carelessness in a matter in which the law mandates carefulness. A breach of this duty gives a

266 Parmananda Katara Vs. Union of India
patient the right to initiate action against negligence. Persons who offer medical advice and treatment implicitly state that they have the skill and knowledge to do so, that they have the skill to decide whether to take a case, to decide the treatment, and to administer that treatment. This is known as an "implied undertaking" on the part of a medical professional. The Supreme Court held that every doctor "has a duty to act with a reasonable degree of care and skill".267 Doctors in India may be held liable for their services individually or vicariously unless they come within the exceptions specified in the case of Indian Medical Association Vs. V P Santha268. Doctors are not liable for their services individually or vicariously if they do not charge fees. Thus free treatment at a Non- Government hospital, Governmental hospital, health centre, dispensary or nursing home would not be considered a "service" as defined in Section 2 (1) (0) of the Consumer Protection Act, 1986. However, no human being is perfect and even the most renowned specialist could make a mistake in detecting or diagnosing the true nature of a disease. A doctor can be held liable for negligence only if one can prove that she/ he is guilty of a failure that no doctor with ordinary skills would be guilty of if acting with reasonable care269. An error of judgment constitutes negligence only if a reasonably competent professional with the standard skills that the defendant professes to have, and acting with ordinary care, would not have made the same error270.

In a key decision on this matter in the case of Dr Laxman Balkrishna Joshi Vs Dr Trimbak Bapu Godbole, the Supreme Court held that if a doctor has adopted a practice that is considered "proper" by a reasonable body of medical professionals who are skilled in that particular field, he or she will not be held negligent only because something went wrong. Doctors must exercise an ordinary degree of skill271. However, they cannot give a warranty of the

270 Whitehouse Vs. Jordan (1981) 1 All ER 267 the House of Lords.
perfection of their skill or a guarantee of cure. If the doctor has adopted the right course of treatment, if she/he is skilled and has worked with a method and manner best suited to the patient, she/he cannot be blamed for negligence if the patient is not totally cured. Certain conditions must be satisfied before liability can be considered. The person who is accused must have committed an act of omission or commission; this act must have been in breach of the person’s duty; and this must have caused harm to the injured person. The complainant must prove the allegation against the doctor by citing the best evidence available in medical science and by presenting expert opinion. In some situations the complainant can invoke the principle of res ipsa loquitur or “the thing speaks for itself”. In certain circumstances no proof of negligence is required beyond the accident itself. The National Consumer Disputes Redressal Commission applied this principle in Dr. Janak Kantimathi Nathan Vs. Murlidhar Eknath Masane. The principle of res ipsa loquitur comes into operation only when there is proof that the occurrence was unexpected, that the accident could not have happened without negligence and lapses on the part of the doctor, and that the circumstances conclusively show that the doctor and not any other person was negligent.

4.4.4. Liability of Health Professional under the Law of Tort

Most civil cases are determined using theories contained in the law of torts. Personal injury lawsuits are usually based on the tort law premise that when someone does something that harms another person physically, mentally, or financially, the person who suffers the harm ought to be compensated for the loss and the person who caused the loss should pay. Whether a civil lawsuit based on tort law will succeed or not depends on the type of tort committed. All health professionals are under legal duty and ethics to perform in a


\[273\] Dr Laxman Balkrishna Joshi Vs Dr Trimbak Bapu Godbole A.I.R. 1969 (SC)128

\[274\] Dr Janak Kantimathi Nathan vs Murlidhar Eknath Masane 2002 (2) CPR 138.
prescribed form (commission) and to strain from performing predetermined acts (omissions). In fact, medical professionals as other professionals in other fields are supposed to behave ethically which is more than what the law requires them to do. Medical negligence comprises the majority of professional negligence lawsuits. This is not to say that medical professionals are more prone to committing negligence, but that they are the target of more professional negligence lawsuits. A person establishes a basic case of medical negligence by establishing four elements. The final theory of tort liability, strict liability, applies to very dangerous activities. If someone does something extremely dangerous, and someone gets hurt as a result, the injured person can sue for damages without having to prove the defendant acted negligently or with intent to cause harm. The principle behind strict liability lawsuits is that some activities are so dangerous that, in exchange for permission to engage in the activity, the actor must assume total responsibility for any resulting damage.

4.4.5. Negligence under the Law of Torts

There is no statutory definition of negligence. In the absence of any such definition we have followed the principle of English common law. The classic judicial definitions of 'negligence' are found in the authoritative treatise of Salmond on the Law of Tort as under:

It is negligence in the objective sense that is referred to in the well-known definition of Alderson B. Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would, or doing something which a prudent and reasonable man would not do. As Lord Wright said: In strict legal analysis, negligence means more than heedless or careless conduct, whether in omission or commission; it properly connotes the complex concept of duty,

275 CPR 49-1 Kerala has, however, enacted a legislation known as Kerala Torts (Miscellaneous Provisions) Act 1976, which provides, inter alia, the definition for various torts including contributory negligence.
breach and damage thereby, suffered by the person to whom the duty was 
owing.' Thus negligence as a tort, is the breach of a duty caused by omission to 
do something which a reasonable man would do, or doing something, which a 
prudent and reasonable man would not do. The definition of negligence 
involves the following constituents:

The breach of duty may be occasioned either by not doing something 
which a reasonable man, under a given set of circumstances would do, or, by 
doing some act which a reasonable prudent man would not do. So far as persons 
engaged in the medical profession are concerned, it may be stated that every 
person who enters into the profession undertakes to bring to the exercise of it, a 
reasonable degree of care and skill. It is true that a doctor or a surgeon does not 
undertakes that he will positively cure a patient nor does he undertake to use the 
highest possible degree of skill, as there may be persons more learned and 
skilled than he. But he definitely undertakes to use a fair, reasonable and 
competent degree of skill276. In Halsbury's Laws of England, the question of 
negligence and duties to the patient has been dealt with on the basis of various 
precedents, wherefrom some paragraphs are reproduced hereunder:

4.4.6. Health professionals: Legal Responsibilities

The conduct of whether action or omission, which may be declared and 
treated as negligence without any argument or proof as to the particular 
surrounding circumstances, either because it is in violation of a statute or valid 
municipal ordinance, or because it is so palpably opposed to the dictates of 
common prudence that it can be said without hesitation or doubt that no careful 
person would have been guilty of it. As a general rule, the violation of a public 
duty, enjoined by law for the protection of person or property, so constitutes. 
The Court held that where a person is guilty of negligence per se, no further

proof is needed. In *Spring Meadows Hospital Vs. HarjolAhuwalia*\textsuperscript{277} the Supreme Court observed: In the case in hand we are dealing with a problem which centers round the medical ethics and as such it may be appropriate to notice the broad responsibilities of such organizations who in the garb of doing service to the humanity have continued commercial activities and have been mercilessly extracting money from helpless patients and their family members and yet do not provide the necessary services. The influence exhorted by a doctor is unique. The relationship between the doctor and the patient is not always equally balanced. The attitude of a patient is poised between trust in the learning of another and the general distress of one who is in a state of uncertainty and such ambivalence naturally leads to a sense of inferiority and it is, therefore, the function of medical ethics to ensure that the superiority of the doctor is not abused in any manner. It is a great mistake to think that doctors and hospitals are easy targets for the dissatisfied patient. It is indeed very difficult to raise an action of negligence. Not only there are practical difficulties in linking the injury sustained with the medical treatment but also it is still more difficult to establish the standard of care in medical negligence of which a complaint can be made.

All these factors together with the sheer expense of bringing a legal action and the denial of legal aid to all but the poorest operate to limit medical litigation in this country. In recent days there has been increasing pressure on hospital facilities, falling standard of professional competence and in addition to all, the ever-increasing complexity of therapeutic and diagnostic methods and all this together are responsible for the medical negligence. There has been a growing awareness in the public mind to bring the negligence of such professional doctors to light. Very often in a claim for compensation arising out of medical negligence a plea is taken that it is a case of bona fide mistake, which under certain circumstances may be excusable, but a mistake, which

would tantamount to negligence cannot be pardoned. In the former case a Court can accept that ordinary human fallibility precludes the liability while in the latter the conduct of the defendant is considered to have gone beyond the bounds of what is expected to the reasonably skill of a competent doctor.

4.4.6.1. Professional Negligence

In the context of the law relating to professional negligence, the learned authors have accorded professional status to seven specific occupations, namely, (i) architects, engineers and quality surveyors, (ii) surveyors, (iii) accountants, (iv) solicitors, (v) barristers, (vi) medical practitioners, and (vii) insurance brokers. The Supreme Court in *Bihari Lal Vs. J.N. Shrivastava* ruled that a charge of professional negligence against a medical man was serious. It stood on a different footing to a charge of negligence against the driver of a motorcar. The consequences were far more serious. It affected his professional status and reputation. The burden of proof was correspondingly greater. As the charge was so grave, so should the proof be clear. With the best will in the world, things sometimes go amiss in

4.4.6.2. Liability of Health Professionals

As regards the liability of Health Professionals, the Supreme Court, while clarifying the duties of a doctor towards the patient in *Laxman Balkrishna Joshi Vs. Dr Trimbak Bapu Godbole* ruled that a person who holds himself ready to give medical advice and treatment undertakes that he is possessed of skill, and knowledge for the purpose. A doctor when consulted by a patient owes certain duties viz, (a) A duty of care in deciding whether to undertake the case; (b) A duty of care in deciding what treatment to give; or (c)

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278 Indian Medical Association Vs. VI' Sh.int.i (1995) 6 SCC 651, SC Aggarwal J, referring to Jackson & Powell on Professional Negligence, third edn, paras 1-01 and 1-03.
279 A.I.R. 1985 MP 158.
280 A.I.R. 1969 SC 128
A duty of care in the administration of that treatment. A breach of any of the aforesaid duties gives a right of action for negligence to the patient.

The Supreme Court, while clarifying the position as early as in 1906 held that it is a good defence in an action by a surgeon or an apothecary that he treated the patient ignorantly or improperly. In a case where a demand is compounded of skill and things administered, if the skill, which is a principal part, is wanting, the action fails, because the defendant has received no benefit. The Supreme Court ruled that the law recognizes the dangers, which are inherent in surgical operations. The Court added that mistakes may occur despite the exercise of reasonable skill and care. Where the operation is a race against time, the Court will make greater allowance for mistakes on the part of the surgeon or his assistants, raking to account the 'risk-benefit' test. However, a mistake by a medical practitioner which no reasonably competent and a careful practitioner would have committed is a negligent one. Liability of 'quacks': Liability of a Homoeopath for Practicing the Allopathic System of Medicine

4.4.6.3. Duties owed to patient

Towards the duties owed to patient by the doctor holds himself out as ready to give medical advice or treatment impliedly undertaken that he is proposed of skill and knowledge for the purpose. Such a person, whether he is a registered medical practitioner or not, who is consulted by a patient owes him certain duties, Namely a duty of cure in deciding whether to undertake the case: a) A duty of care in deciding what treatment is to be given finds a duty of care

281 Domingo M Parreira Vs. Gabriel F Gonsalves(1906) 8 Bom LR 93.
283 A.S. Mittal Vs. State of Uttar Pradesh
284 'Quack' is a person who does not have knowledge of a particular system of medicine but practices in that system and is a mere pretender to medical knowledge or skill or to put it differently a 'Charlatan'. They are guilty of negligence 'perse'. (See A vtar Singh Bhatora Vs. Dr Swam Prakash Garg (2001) 1 CPR 44.
in his administration of that treatment. b) A breach of any of these duties will support an action for negligence by the patient.

4.4.6.4. **Degree of skill and care required**

The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest, nor the very lowest degree of care and competence judged in the light of the particular circumstances of each case, is what the law requires. A person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operation in a different way; is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art, although a body has adverse opinion existed among medical men. In India it is well settled that the general principles of law of tort are equally relevant and applicable. The development of the law of tort is in the line and closely similar, if not identical with its parental concept. What is covered under the law of tort may again be found with reference to the authoritative enunciation in Salmond on the Law of Torts, wherein with particular reference to this category, it has been summed up as under:

4.4.6.5. **Concept of Duty to Take Care**

The concept of duty to take care by the professionals, the Supreme Court, in *Indian Medical Association vs. VP Shantha*[^285] ruled that a person who is not qualified to practice allopathy was a quack or pretender to the medical knowledge and skill, or a charlatan. He is liable to be prosecuted under sub- *Section (3)* of *Section 15* the Medical Councils Act 1956 and is guilty of negligence, particularly in view the duty of care laid down by the Supreme Court in Dr Laxman Joshis case[^286]. The Court further ruled that professional

men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as well as in contract, to exercise reasonable care "giving advice or performing services. Immunity from suit has been enjoyed by certain professions on the grounds of public interest. The trend now is the narrowing of such immunity. Medical practitioners do not enjoy any immunity and they can be sued in contract or tort on the ground that they have failed to exercise reasonable skill and care. Thus medical practitioners, though belonging to the medical profession, are not immune from a claim for damages on the ground of negligence.

➢ The Supreme Court in Achutrao H.Khodwa Vs. State of Maharashtra\(^{287}\) pointed out that the skill of medical practitioners varies 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 his 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 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 guilty of negligence.

➢ Liability of a doctor for not advising the patient to approach a better hospital: In Ram Bihari Lal Vs. J N Shrivastava\(^{288}\) the operation theatre was under repair. There were no facilities for oxygen and blood transfusions, there was no anaesthetist, and some life saving drugs were not available. Pipettes for testing blood were broken, the saline

\(^{287}\) A.I.R. 1996 SC 2383.
\(^{288}\) A.I.R. 1985 MP 150.
apparatus was not in order, and there were only two staff nurses for a 28-bed hospital. In these circumstances the Supreme Court ruled that the doctor should not have undertaken such a major operation in a hospital, which was lacking basic facilities. He should have advised plaintiff no 1, after he found that an operation was required, to take his wife to Rewa Medical College, which was not far off, and had all the facilities including specialists availability. The doctor, therefore, failed in his duty of care in undertaking the operation without taking necessary precautions.

Difference in standard of care of doctors attached with the companies/factories from those of general doctors: The Supreme Court in *Philips India Ltd, Vs. Kunju Punnu and anr.* of ruled that the duty cast on the company's

4.4.6.6. Reasonable Skill

The degree of skill a doctor undertakes is the average degree of skill possessed by his professional brethren of the same standing as himself. The best form of treatment may differ when different choices are available. There is an implied contract between the doctor and the patient when the patient is told in effect: "Medicine is not an exact science. I shall use my experience and best judgment and you take the risk that I may be wrong. I guarantee nothing." *Not to undertake any procedure beyond his skill:* This depends upon his qualifications, special training and experience. The doctor must always ensure that he is reasonably skilled before undertaking any special procedure/treating a complicated case. To quote an example, a doctor who is not sufficiently trained or qualified should not administer anesthesia.

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4.4.6.7. Civil Liability of Doctors/Hospitals for Negligence

In context of civil liability of doctors or hospitals for negligence there are certain principles has been set out by the Privy Council. They are - (i) Degree of negligence: The Privy Council in *John Oni Akerele Vs. The King* ruled that the degree of negligence required is hold a doctor liable is that: (ii) It should be gross; (iii) Neither a jury nor a Court can transform negligence of a lesser degree into gross negligence merely by giving it that appellation; and (iv) Negligence to be imputed depends upon the probable, not the actual result. The law requires that the practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires\(^{290}\).

In *Balbir Sing Makol Vs. Chairman, M/s Sir Ganga Ram Hospital*\(^ {291} \) and on the National Commission dealt with the most contentious issue of liability of legal representatives of the doctor for the negligent acts of the doctor after his death. The Commission while dismissing the complaint relied on the maxim *action persona is moritur cum persona*\(^ {292} \), which as a general rule is applicable to actions in torts and, therefore, the cause of action against the party against whom an action in tort is brought is extinguished on his death. It is held that the legal representatives of the deceased doctor not liable to pay compensation. While arriving at the above conclusion the Commission relied upon the decision of the Supreme Court in *G Jayaprakash Vs. The State of Andhra Pradesh*\(^ {293} \), wherein it was held that the death of the doctor extinguished his liability for damages and the suit against him stood abated. The maxim, action personal is moritur cum\person is to be applied to the case.


\(^{291}\) (2001) 1 CPR 49.

\(^{292}\) Means a personal right of action dies with the person. In other words, death destroys the right of action.

4.5. Criminal Negligence

Criminal law is applicable to all individuals and doctors are no exception to it. As far as medical practice is concerned patients or relatives usually don't approach the police. But now-a-days this scenario is also changing. In last few decades as doctor patient relationship has deteriorated, the complaints against doctors have increased. According to the provisions of Indian Penal Code 1860 any act of commission or omission is not a crime unless it is accompanied by a guilty mind i.e mens rea. The acts are not punishable only because it led to some mischievous results unless associated with intention or mental attitude of the person. Most of the times doctors treatment is in good faith, with the consent of the patient and hence most of the provisions of IPC are not applicable to the doctors unless or until there is rashness or gross negligence. In criminal law, consent and actus reus play an important role in deciding the cases of criminal liability of a person. The real question often raised in the criminal liability of health professionals is why should a doctor insist on consent from his patient for the course of treatment to be adopted by him? Consent from the patient is for the protection of the physician or the surgeon. Every surgery, whether minor or major is fraught with some degree of hazard or risk, which varies in accordance with the seriousness of the disease.

If a patient collapses during the course of a surgery or during the course of a treatment, law gives protection to the medical man, provided, he establishes that the risky step was adopted with the consent, express or implied, from the patient. In fact, it is a defence available to the doctor as envisaged in Section 88 of the Indian Penal code the consent factor may be important very often in cases of selective operations, which may not be imminently necessary to save the patient's life. But there can be instances where a surgeon is not expected to say that did not operate on him because, I did not get his consent'. Such cases include emergency operations, where a doctor cannot wait for the consent of his patient, or where the patient is not in a fit state of mind to give,
or not to give a conscious answer regarding consent. Even if he is in a fit condition to give a voluntary answer, the surgeon has a duty to inform him of the dangers ahead or the risks involved by going without an operation at the earliest. In this context, it would be relevant to refer to a passage from 'Law and Medical Ethics' under the sub-title 'Is consent always necessary?' The relevant passage runs as under: As a general rule, medical treatment, even of a minor nature, should not proceed unless the doctor has first obtained the patient's consent. This consent may be express or it may be implied, as it is when the patient presents himself to the doctor for examination and acquiesces in the suggested routine. Here the negligence is so great as to go beyond matter of mere compensation. Not only has the doctor made a wrong diagnosis and treatment, but also that he has shown such gross ignorance, gross carelessness or gross neglect for the life and safety of the patient that a criminal charge is brought against him. For this he may be prosecuted in a Criminal Court for having caused injury to or the death of his patient by a rash and negligent act amounting to culpable homicide under Section 304-A of the Indian Penal Code. Some examples are as follows:

Injecting anesthetic in fatal dosage or in wrong tissues: Amputation of wrong finger, operation on wrong limb, removal of wrong organ, or errors in ligation of ducts.

- Operation on wrong patient.
- Leaving instruments or sponges inside the part of body operated upon.
- Leaving tourniquets too long, resulting in gangrene.
- Transfusing wrong blood.
- Applying too tight plaster or splints which may cause gangrene or paralysis.
- Performing a criminal abortion.

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Role of nurses in public policy issues and Right to give Information:

There is now a growing concern that care expenditure is rising at an alarmingly uncontrolled rate. The changes in economic policies of the nation's globalization, liberalization and privatization under the presiding triad the World Bank, the International Monetary Fund and the World Trade Organization has no doubt contributed to the sweeping changes that we see today. With escalating health care expenditures, increasing privatization of health care and reduction in the percentage allocation in the financial outlay of the Government, the major public policy issue facing health care is the area of strategies for cost containment for controlling health care expenditure. This is a challenge to the health care consumers, health care providers, the Government who has the responsibility for health care of the vast majority. The third party payers for the better off including a section of the organized working class, the insurance sector. Which are the key determinants in the health sector.

Public nuisance\textsuperscript{295}: A person is guilty of a public nuisance, who does any act, or is guilty of an illegal omission, which causes any common injury, danger, or annoyance to the public or to the people in general who dwell or occupy property in the vicinity or which must necessarily cause injury, obstruction, danger, or annoyance to persons who may have occasion to use any public right. A common nuisance is not excused on the ground that it causes some convenience or advantage.

Negligent act likely to spread infection of disease dangerous to life\textsuperscript{296}: Whoever unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.\textsuperscript{297}

\textsuperscript{295} Section 268
\textsuperscript{296} Section 270
\textsuperscript{297} Section 269
Malignant act likely to spread infection of disease dangerous to life: Whoever malignantly does any act which is, and which he knows or had reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

Disobedience to quarantine rule: Whoever knowingly disobeys any rule made and promulgated by the Government for putting vessel into a state of quarantine, or for regulating the intercourse of vessels in a state of quarantine with the shore or with other vessels, or for regulating the intercourse between places where an infectious disease prevails and other places, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.\(^{298}\)

Adulteration of food or drink intended for sale: Whoever, adulterates any article of food or drink, so as to make such article noxious as food or drink, intending to sell such article as food or drink, or knowing it to be likely that the same will be sold as food or drink, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to one thousand rupees or with both.\(^{299}\)

Sale of noxious food or drink: Whoever sells, or offers or exposes for sale, as food or drink, any article which has been rendered or has become noxious, or is in a state unfit for food or drink, knowing or having reason to believe that the same is noxious as food or drink, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to one thousand rupees or with both.\(^{300}\)

Fouling water of public spring or reservoir: Whoever voluntarily corrupts or fouls the water of any public spring or reservoir, so as to render it

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298 Section 271
299 Section 272
300 Section 273
less fit for the purpose for which it is ordinarily used, shall be punished with imprisonment of either description for a term which may extend to three months, or with fine which may extend to five hundred rupees, or with both.\textsuperscript{301}

\textit{Making atmosphere noxious to health:} Whoever voluntarily vitiates the atmosphere in any place so as to make it noxious to the health of persons in general dwelling or carrying on business in the neighborhood or passing along a public way, shall be punished with fine which may extend to five hundred rupees.\textsuperscript{302}

\textit{Negligent conduct with respect to poisonous substance:} Whoever does, with any poisonous substance, any act in a manner so rash or negligent as to endanger human life, or to be likely to cause hurt or injury to any person, or knowingly or negligently omits to take such order with any poisonous substance in his possession as is sufficient to guard against any probable danger to human life from such poisonous substance, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to one thousand rupees or with both.\textsuperscript{303}

\textit{Negligent conduct with respect to fire or combustible:} Matter: whoever does, with fire or any combustible matter, any act so rashly or negligently as to endanger human life, or to be likely to cause hurt or injury to any other person, or knowingly or negligently omits to take such Her with any fire or any combustible matter in his possession as is sufficient to guard against any probable danger to human life from such fire or combustible matter, shall be punished with imprisonment of either description for a term which may extend to six months or with fine which ay extend to one thousand rupees or with both.\textsuperscript{304}

\textsuperscript{301} Section 277
\textsuperscript{302} Section 278
\textsuperscript{303} Section 284
\textsuperscript{304} Section 285
Negligent conduct with respect to explosive substance: Whoever does, with any explosive substance, any act so rashly or negligently as to endanger human life, or to be likely to cause hurt or injury to any other person, or knowingly or negligently omits to take such order with any explosive substance in his possession as is sufficient to guard against any probable danger to human life from that substance, shall be punished with imprisonment of either description for a term which may extend to six months or with fine which may extend to one thousand rupees or with both.\textsuperscript{305}

Negligent conduct with respect to machinery: Whoever does, with any machinery, any act as rashly or negligently as to endanger human life or to be likely to cause hurt or injury to any other person, or knowingly or negligently omits to take such order with any machinery in his possession or under his care as is sufficient to guard against any probable danger to human life from such machinery, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to one thousand rupees, or with both.\textsuperscript{306}

Negligent conduct with respect to pulling down or repairing buildings: Whoever, in pulling down or repairing any building, knowingly or negligently omits to take such order with that building as is sufficient to guard against any problem danger to human life from the fall of that building or any part thereof, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to one thousand rupees or with both.\textsuperscript{307}

Culpable Homicide: Whoever causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury as

\textsuperscript{305} Section 286  
\textsuperscript{306} Section 287  
\textsuperscript{307} Section 288
is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide\textsuperscript{308}.

\textit{Explanation 1}: A person, who causes bodily injury to another who is labouring under a disorder, disease or bodily infirmity, and thereby accelerates the death of that other, shall be deemed to have caused his death.

\textit{Explanation 2}: Where death is caused by bodily injury, the person who causes such bodily injury shall be deemed to have caused the death, although by resorting to proper remedies and skilful treatment the death might have been prevented.

\textit{Explanation 3}: The causing of the death of a child in the mother's womb; is not homicide. But it may amount to culpable homicide to cause the death of a living child, if any part of that child has been brought forth, though the child may not have breathed or been completely born.

\textit{Murder}\textsuperscript{309}: Except in the cases hereinafter excepted, culpable homicide is murder, if the act by which the death is caused is done with the intention of causing death, or

\textit{Secondly}: it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused, or

\textit{Thirdly}: If it is done with the intention of causing bodily injury to any person and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death, or

\textit{Fourthly}: If the person committing the act knows that it is so imminently dangerous that it must, in all probability, cause death or such bodily

\textsuperscript{308} Section 299
\textsuperscript{309} Section 300
injury as is likely to cause death, and commits such act without any excuse for incurring the risk of causing death or such injury as aforesaid.

**Exception 1.** When culpable homicide is not murder: Culpable homicide is not murder if the offender, whilst deprived of the power of self control by grave and sudden provocation, causes the death of the person who gave the provocation or causes the death of any other person by mistake or accident.

The above exception is subject to the following provisions:

**First:** That the provocation is not sought or voluntarily provoked by the offender as an excuse for killing or doing harm to any person.

**Secondly:** That the provocation is not given by anything done in obedience the law, or by a public servant in the lawful exercise of the powers of such public servant.

**Thirdly:** That the provocation is not given by anything done in the lawful exercise of the right of private defence.

Causing death by negligence: Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable, homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

Act not intended to cause death, done by consent in good faith for person's benefit: Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied, to suffer that harm, or to take the risk of that harm. 'Good Faith': Nothing, is

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310 Section 304A
311 Section 88
said to be done or believed in 'good faith' which is done or believed without due care and attention.\textsuperscript{312}

4.5.1. Liability of Health Professionals

Doctor in respect to the company's employees is not any higher or lower than the duty of an average doctor towards his patient. The Supreme Court, in its landmark judgment in \textit{Parmanand Katara Vs. Union of India and ors} ruled that every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life. No law or State action can intervene to avoid/delay the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained, and must therefore, give way\textsuperscript{313}.

\textit{Oral consent admissibility:} The State Consumer Redressal Commission, Chennai, in \textit{Arunachala Vadivel and ors Vs. Dr N Gopalkrishnaih}\textsuperscript{314} ruled that in all cases where a treatment consists of certain dangerous instruments, it is the duty of the medical authority to take the consent of the patient, preferably in writing. According to RWI, he instructed his nurse to take the consent, but she has failed to do so. However, there is no doubt that there was the oral consent of the patient for conducting this operation. The patient was conscious all along till anaesthesia was administered in the operation theatre. She, therefore, fully knew the pre-operative injections administered and when she was taken into the theatre, her relations were also aware of it. Therefore, there was no negligence or deficiency of service in the preparation of the patient for the surgery.

\textsuperscript{312} Section 52
\textsuperscript{313} For a detailed description of duties of doctors in accident cases see chapter 2.
\textsuperscript{314} (1992) 2 CPR 548.
Necessity of obtaining the consent of patient before an operation during an emergency: The Supreme Court in *TT Thomas vs. Elisa*[^15], ruled that:

- Failure to perform emergency operation and the death of the patient on account of such failure amounts to negligence on part of surgeon.

- The burden is on the surgeon to prove that the non-performance of the surgery or the non-administration of the treatment was on account of the refusal of the patient to give consent thereto. A surgeon, who fails to perform an emergency operation, must prove with satisfactory evidence that the patient refused to undergo the operation, not only at the initial stage but even after he was informed of the dangerous consequences of not undergoing the operation.

- Consent is implicit in the case of a patient who submits to a doctor, and the absence of consent must be made out by the person alleging it.

**Liability of Government hospitals/Doctors:** The Supreme Court, in *Achutrao H Khodwa Vs. State of Maharashtra*[^316] while overruling the judgment of the High Court, made it clear that the Government cannot be held liable in tort for acts committed in a hospital that was not maintained, because the High Court considered that maintaining and running a hospital was an exercise of the State's sovereign function. Disapproving this line of thinking, the Supreme Court held that running a hospital is a welfare activity undertaken by the Government, but is not an exclusive function or activity of the Government so as to be classified as one which could be regarded as being in exercise of its sovereign power. The Court referred to its earlier decision in *Kasturilal's case*[^317] wherein it was noticed that in pursuit of the welfare ideal,  

[^15]: A.I.R. 1987 Ker 52.  
the Government may enter into many commercial and other activities which have no relation to the traditional concept of Governmental activity in exercise of its sovereign function, similarly the running of a hospital, where the members of the general public can come for treatment, cannot be regarded as being an activity having a sovereign character. Applying this principle, the Court held that the State would be vicariously liable for the damages which may become payable on account of negligence of its doctors or other employees.

Again the Supreme Court, in Paschim Bangal Khet Mazdoor Samity and ors Vs. State of WB and anor,\textsuperscript{318} ruled that it is the Constitutional obligation of the State to provide adequate medical services to the people to preserve human life. The State cannot avoid its Constitutional obligation in that regard on account of financial constraints. In the matter of allocation of funds for medical services they said national obligation of the State has to be kept in view. It is necessary that a time bound plan for providing these services should be chalked out for ensuring availability of proper medical services in this regard, as indicated by the Court. The State of West Bengal alone was a party to these proceedings Other States, though not parties, should also take necessary in the light of the recommendations made by the committee, the dictions contained in the memorandum of the Government of West Bengal dated 22nd August 1995, and the further directions given by the Court. The Court further ruled that the petitioner should, therefore, be suitably compensated for the breach of his right guaranteed under art 21 of the Constitution. Having regard to the facts and circumstances of the case, the amount of compensation was fixed at Rs 25,000.

\textit{Vicarious liability of the Government for the acts of its servants}: The Supreme Court in Achutrao H Khodwa Vs. State of Maharashtra\textsuperscript{319} made it clear that even if it is assumed that it is the second operation performed by Dr

\begin{itemize}
\item \textsuperscript{318} (1996) 4 SCO 37.
\item \textsuperscript{319} A.I.R. 1996 SC 2383.
\end{itemize}
Divan which led to the peritonitis, as has been deposed to by Dr Purandare, the fact still remains that but for the leaving of the mop inside the peritoneal cavity, it would not have been necessary to have the second operation. Assuming that the second operation was done negligently, or that there was lack of adequate care after the operation, which led to peritonitis, the fact remains that Dr. Divan was an employee of respondent no 1 and the State must be held to be vicariously liable for the negligent acts of its employees working in the said hospital. The claim of the appellants cannot be defeated merely because it may not have been conclusively proved as to which of the doctors employed by the State in the hospital or other staff acted negligently which caused the death of Chandrikabai. Once death by negligence in the hospital is established, as in the case here, the State would be liable to pay damages. In the Supreme Court's opinion, therefore, the High Court clearly fell in error in reversing the judgment of the trial Court and in dismissing the appellant's suit.

Vicarious liability of owner of hospital: The Supreme Court in Joseph alias Pappachan and ors Vs. Dr George Moonjely and anro ruled that regarding the vicarious liability of those who run hospitals for the negligent acts of the doctors employed by them, the question is no longer res Integra. Arsons who run a hospital are in law under the self-same duty as the humblest doctor. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves; they have no ears to listen through the stethoscope, and no hands to hold the surgeon's scalpel. They must do it by the staff, they employ, and if their staff is negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him. Therefore, the first defendant is primarily liable for his negligent act, and the second defendant being 1 owner of the hospital, is vicariously liable for the negligent conduct of I first defendant.

Res Ipsa Loquitur

Principles for the applicability of the doctrine: When an unexplained accident occurs from a thing under the control of the defendant, and medical or other expert evidence shows that such accidents would not happen proper care were taken, there is at least evidence of negligence for a jury.\(^{321}\)

The two conditions for the applicability of the maxim are:

- That the thing causing the damage be under the exclusive control of, the defendant; and
- That the accident must be such as would not in the ordinary course of things have happened without negligence.

Where the doctrine applies, a presumption of fault is raised against the defendant who, must overcome by contrary evidence, if he is to succeed in his defence. The burden on the defendant being to show how the act complained of could reasonably happen without negligence on his part.\(^{322}\) It may be further noted, however, that if facts are sufficiently known, the question ceases to be one where facts speak for themselves, and the solution is to be found by determining whether, on the facts as established, negligence is to be inferred or not.\(^{323}\) It is in the light of the law stated above the application of the maxim needs be examined in cases of medical negligence. In *Mohan Vs. Osborne*\(^{324}\) a swab used by the surgeon to pack off adjacent from the areas of the operation was left at the end of an abdominal operation in the patient's body, as a result of which he died within three months McKinnon and Goddard LJ held ruled that the doctrine of *res ipsa loquitur* was applicable, so as to shift the burden of the defendant, Goddard LJ in a concurring but separate judgment observed:

\(^{323}\) [1950] 1 All HR 392 at pp 394-395; quoted with approval in State of Punjab Vs. Modern Cultivators A.I.R. 1965 SC 17.
\(^{324}\) (1939) 2 KB 14.
Award of compensation on the basis of age and salary of the deceased:

In *Poonam Verma Vs. Ashwin Patel*\(^{325}\) the deceased was 35 years of age and was getting a salary Rs 5700 per month. He died a young death, which has deprived his dependants, namely, the widow, two children and parents, of the monetary benefit they were getting. The Supreme Court, while determining the compensation held that they were entitled under law to be compensated. The claim of the appellant was decreed as against respondent for a sum of Rs three lakhs payable to her within three months from the date of the present judgment, failing which would be recoverable in accordance with the law. The Court further ruled that the appellant would be entitled to her costs, which were quantified at Rs 30,000.

Enhancement of claims: The Supreme Court in *Ram Bihari Lal Vs. JN Shrivastava*\(^{326}\), found that the defendant failed in his duty of care in detaching the operation and in doing the operation without taking necessary precautions. His act of removing the gall bladder was highly hazardous which resulted in the death of the patient. So the defendant was liable to pay damages for his wrongful acts. However, the plaintiffs are only claiming symbolical damages. The award of Rs 3000 for loss of service at the rate of Rs 25 per month for 10 years, on the death of a young mother of seven minor children, the youngest aged four and a half months, is not adequate. The award of Rs 1000 for mental agony and physical suffering is also very low. However, there was no claim for enhancement.

With the enactment of the Consumer Protection Act, the consumers may take recourse to the provisions under the Consumer Protection Act. But it may be noted herein that the scope of the remedies provided under the law of tort is wider than other legislations. Under this head a person can file a petition even against Government servants for the loss or injury sustained by them due to their negligent acts. The scope and the ambit of liability of health professionals

\(^{325}\) (1996) 4 SCC 332.

\(^{326}\) A.I.R. 1985 MR 150.
and the State agencies has been widened by the Supreme Court enabling the consumers to redress their grievances by approaching the appropriate Court for immediate relief. A review of the cases decided by the Courts under the law of tort reveals that the courts have mainly relied upon the principles such as: (i) test of reasonable foresight; (ii) duty to care; and (iii) loss or injury. The Court has taken the charge of professional negligence against a person to be of serious nature, and has awarded compensation in such cases. The Court has at the same time recognized the dangers, which are inherent in surgical operations and for wrong diagnosis, not amounting to an act of negligence. According to the Courts, a doctor is not required to take the highest degree of care but he is only required to act in accordance with the practice accepted as proper, by a reasonable body of medical men skilled in that particular art. The court stated that professional men should possess a certain minimum degree of competence, that they should exercise reasonable care in the discharge of their duties. Keeping this in view, the Medical Council should strictly monitor the educational institutions providing medical education and awarding degrees to practice. It should also take measures to test the competence of doctors from time to time. Further, the MCI should take steps to provide information about the latest development in the field of medical technology including prescription of medicines and conducting major operations from time to time.

The Court drew no distinction between doctors working Government hospitals or private hospitals. It imposes a duty upon all the doctors to protect the life of the patients. The Court has taken a serious view where a surgeon failed to perform an emergency operation, which resulted in the death of the patient. There is a need to sensitize doctors and other medical professional about the importance of providing immediate medical aid to injured persons. This is even in medico-legal cases irrespective of the fact whether the patient is innocent or a criminal. As suggested by the Supreme Court, it is the duty of the doctor to extend medical assistance to save the life of patients. The doctors may follow the legal procedure after giving the necessary medical aid.
4.5.2. Health Care and Protection under the Indian Penal Code 1860

Criminal negligence is an important provision of law apart from the civil negligence which sets an example for the society that the people would be punished for their negligence, if they commit similar nature of offence. Some of the important provisions of Indian Penal Code has been studied here under. Section 304A of the Indian Penal Code of 1860 states that whoever causes the death of a person by a rash or negligent act not amounting to culpable homicide shall be punished with imprisonment for a term of two years, or with a fine, or with both. In the Santra case, the Supreme Court has pointed out that liability in civil law is based upon the amount of damages incurred; in criminal law, the amount and degree of negligence is a factor in determining liability. However, certain elements must be established to determine criminal liability in any particular case, the motive of the offence, the magnitude of the offence, and the character of the offender. In Poonam Verma Vs. Ashwin Patel the Supreme Court distinguished between negligence, rashness, and recklessness. A negligent person is one who inadvertently commits an act of omission and violates a positive duty.

A person who is rash knows the consequences but foolishly thinks that they will not occur as a result of her/his act. A reckless person knows the consequences but does not care whether or not they result from her/his act. Any conduct falling short of recklessness and deliberate wrongdoing should not be the subject of criminal liability. Thus a doctor cannot be held criminally responsible for a patient’s death unless it is shown that she/he was negligent or incompetent, with such disregard for the life and safety of his patient that it amounted to a crime against the State. Sections 80 and 88 of the Indian Penal Code contain deference's for doctors accused of criminal liability. Under Section 80 (accident in doing a lawful act) nothing is an offence that is done by accident or misfortune and without any criminal intention or knowledge in the

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328 House of Lords decision in R Vs. Adomako (1994) 3 All ER 79
doing of a lawful act in a lawful manner by lawful means and with proper care and caution. According to Section 88, a person cannot be accused of an offence if she/he performs an act in good faith for the other’s benefit, does not intend to cause harm even if there is a risk, and the patient has explicitly or implicitly given consent. The burden of proof of negligence, carelessness, or insufficiency generally lies with the complainant. The law requires a higher standard of evidence than otherwise, to support an allegation of negligence against a doctor. In cases of medical negligence the patient must establish her/his claim against the doctor. Even after adopting all medical procedures as prescribed, a qualified doctor may commit an error. The National Consumer Disputes Redressal Commission and the Supreme Court have held, in several decisions, that a doctor is not liable for negligence or medical deficiency if some wrong is caused in her/his treatment or in her/his diagnosis if she/he has acted in accordance with the practice accepted as proper by a reasonable body of medical professionals skilled in that particular art, though the result may be wrong. In various kinds of medical and surgical treatment, the likelihood of an accident leading to death cannot be ruled out.

It is implied that a patient willingly takes such a risk as part of the doctor-patient relationship and the attendant mutual trust. Before the case of Jacob Mathew Vs. State of Punjab, the Supreme Court of India delivered two different opinions on doctors’ liability. In Mohanan Vs. Prabha G Nair and another, it ruled that a doctor’s negligence could be ascertained only by scanning the material and expert evidence that might be presented during a trial. In Suresh Gupta’s case in August 2004 the standard of negligence that had to be proved to fix a doctor’s or surgeons criminal liability was set at “gross negligence” or “recklessness.” In Suresh Gupta’s case the Supreme Court distinguished between an error of judgment and culpable negligence. It held that criminal prosecution of doctors without adequate medical opinion pointing to their guilt would do great disservice to the community. A doctor cannot be

tried for culpable or criminal negligence in all cases of medical mishaps or misfortunes. A doctor may be liable in a civil case for negligence but mere carelessness or want of due attention and skill cannot be described as so reckless or grossly negligent as to make her/him criminally liable. The Courts held that this distinction was necessary so that the hazards of medical professionals being exposed to civil liability may not unreasonably extend to criminal liability and expose them to the risk of imprisonment for alleged criminal negligence. Hence the complaint against the doctor must show negligence or rashness of such a degree as to indicate a mental state that can be described as totally apathetic towards the patient. Such gross negligence alone is punishable. On September 9, 2004, Justices Arijit Pasayat and CK Thakker referred the question of medical negligence to a larger Bench of the Supreme Court. They observed that words such as “gross”, “reckless”, “competence”, and “indifference” did not occur anywhere in the definition of “negligence” under Section 304A of the Indian Penal Code and hence they could not agree with the judgment delivered in the case of Dr Suresh Gupta. The issue was decided in the Supreme Court in the case of Jacob Mathew Vs. State of Punjab. The Court directed the central Government to frame guidelines to save doctors from unnecessary harassment and undue pressure in performing their duties. It ruled that until the Government framed such guidelines, the following guidelines would prevail.

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

330 Criminal Appeal Nos 144-145 of 2004
4.5.3. Procedure under the Code of Criminal Procedure 1973:

Apart from the provisions of the Statutory law in protection of health care the procedural law in civil as well as criminal plays an important role for the health consumers for getting justice within the reasonable time. The important principles and provisions of law of the Code of Criminal Procedure is studied hereunder.

Public nuisances:
Conditional order for removal of nuisance:

- Whenever a District Magistrate or a Sub-divisional Magistrate or any other Executive Magistrate specially empowered in this behalf by the State Government, on receiving the report of a police officer or other information and on taking such evidence (if any) as he thinks fit, considers.

- That the conduct of any trade or occupation, or the keeping of any goods or merchandise, is injurious to the health or physical comfort of the community, and that in consequence such trade or occupation should be prohibited or regulated or such goods or merchandise should be removed or keeping thereof regulated; or

> Such Magistrate may make a conditional order requiring the person causing such obstruction or nuisance, or carrying on such trade or occupation, or keeping any such goods or merchandise, or owing, possessing or controlling such building, tent, structure, substance, tank, well or excavation, or owing or Possessing such animal or tree, within a time to be fixed in the order to remove such obstruction or nuisance; or

> To desist from carrying on, or to remove or regulate in such manner as may be directed, such trade or occupation, or to remove such goods or merchandise, or to regulate the keeping thereof in such manner as may be directed; or of, if he objects so
to do, to appear, before himself or some other Executive Magistrate subordinate to: him at a time and place to be fixed by the order, and show cause, in the manner hereinafter provided, why the order should not be made; absolute. No order duly made by a Magistrate under this Section shall be called in question in any Civil Court.

Explanation: A 'Public Place' includes also property belonging to the State, camping grounds and grounds left unoccupied for sanitary or recreative purposes.

Section 134: Service or notification or order: (1) The order shall, if practicable, be served on the person against whom it is made, in the manner herein provided for service of a summons, and (2) If such order cannot be so served, it shall be notified by proclamation, published in such manner as the State Government may, by rules, direct, and a copy thereof shall be; stuck up at such place or places as may be fittest for conveying the information to such person. 331

Persons to obey or show cause: The person against whom such order is made shall:

- Perform, within the time and in the manner specified in the order, the act directed thereby; or
- Appear in accordance with such order and show cause against the same. 332

Section 136: Consequences of failing to comply: If such person does not perform such act or appear and show cause, lie shall be liable to the penalty prescribed in that behalf in Section 188 of the Indian Penal Code (45 of 1860), and the order shall be made absolute.

331 Section 133
332 Section 135
Enabling provisions for award of compensation order to pay compensation: This Section empowers the Courts to award compensation to the victims while passing judgment of conviction\textsuperscript{333}. The Supreme Court, in its path breaking judgment the Court observed that in addition to conviction may order the accused to pay some amount by way of compensation who has suffered by action of the accused\textsuperscript{334}.

Any aggrieved person or his family members may lodge a complaint with the police for registration of the First Information Report (FIR). He may seek the assistance of police by dialing 100 or any other specified number. There is no fixed format for writing the complaint. One can write accurately in a language of his choice, giving full details as to names of the accused, place of commission of offence, date and time etc. The complaint may be submitted either orally or in writing in both the events it is the responsibility of then police officer to register his complaint. One should avoid delay in registering the complaint. If there is any delay the reasons for the delay may stated in the complaint. The complainant is also entitled to have a copy FIR and can demand for the same. If a police officer refuses to register a complaint he can approach the higher officials or send the same by registered post or otherwise he can move a private complaint under Section 200 of the Code of Criminal Procedure before a Magistrate, or a petition may be filed before the High Court in the concerned State under art 226 of the Constitution for appropriate directions.

A complaint may also be lodge., with the Executive Magistrate under Sections 133 to 135 of the Code of Criminal Procedure 1973. The aforesaid provisions can be invoked to I eliminate 'quacks' or persons practicing unauthorized in any area and are a threat to the lives of the public. Advice or treatment implies that he is possessed of skill and knowledge for the purpose. Whether or not he is a registered medical practitioner, such a person who is consulted by a patient owes him certain duties, namely: a duty of care in

\textsuperscript{333} Section 357
\textsuperscript{334} Hari Krishna/of Haryana Vs. Sukbhir Singti
deciding whether to undertake the case; a duty of care in deciding what
treatment to give, a duty of care in his administration of that treatment and; a
duty of care in answering a question put to him by a patient in circumstances
in which he knows that the patient, intends to rely on his answer. A breach of
any of these duties will support an action for negligence by the patient. The
practitioner must bring to his task a reasonable degree of skill and knowledge,
and must exercise a reasonable degree of care. Neither the very highest nor the
very lowest degree of care and competence, judged in the light of the particular
circumstances of each case, is what the law requires. A person is not liable in
negligence because someone else of greater skill and knowledge would have
prescribed a different treatment or operated in a different way, nor is he 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 art, even though
a body of adverse opinion also existed among the medical men. Deviation from
normal practice is not necessarily evidence of negligence. To establish liability
on that basis it must be shown that: (1) there is a usual and normal practice; (2)
the defendant has not adopted it; and (3) the course in fact adopted is one which
no professional man of ordinary skill would have taken had he been acting with
ordinary care. It is a defense to a practitioner that he acted on the specific
instructions of a consultant who had taken over responsibility for the case.
Failure to use due skill in diagnosis with the result that wrong treatment is
given in negligence\textsuperscript{335}.

4.5.4. The Role of Consent

\textit{In Juggankhan Vs. State of MP} a registered Homoeopath administered
24d drops of stramonium and a leaf of dhatura without studying their probable
effect to the patient suffering from guinea worm. On these facts the Supreme
Court observed that according to the evidence on record, in no system of
medicine except perhaps in the ayurvedic system, the dhatura leaf is given as

\textsuperscript{335} See Laxman Vs. Trimbak, AIR 1969 SC 128; Ram Bihari Lal Vs. JNShrivastava AIR 158.
cure for guinea worms. It seems that the appellant prescribed the medicine without thoroughly studying what the effect of giving 24 drops of stramonium and a leaf of dhatura would be. The Court added that it is a rash and negligent act to prescribe poisonous medicines without studying their probable effect. Section 299, IPC does not apply in the present case. It must be held that the, appellant administered the stramonium drops and the dhatura leaf with the knowledge that he was likely to cause death by such an act. The Court further held that it is true, that care should be taken before imputing criminal negligence to a professional man acting in the course of his profession, but even taking this care there is no doubt that the appellant was guilty of a rash and negligent act. The Court also held that the two elements, of consent on the part of the patient, and of good faith on the part of the medical practitioner, are inter-dependent and nobody can claim the benefit of this exception without good faith. Thus, the appellant is not entitled to the exception given in Section 88. He was therefore, rightly convicted under Section 302 of IPC. The act was undoubtedly a very callous one because the treatment was repeated in spite of his recent experience in the case of Hiralal. However, the Sessions Judge awarded the lesser penalty, and there was nothing more to be said in that regard. In view of the above, the Court upheld the conviction and sentence and dismissed the appeal accordingly.

Administering Wrong Injection Without Qualifications: In Ram Miwas Vs. State of Uttar Pradesh a person (not a qualified doctor carried on the profession of a doctor) administered a full dose of an injection without giving the test dose and the subsequent reaction, resulted in death. The Allahabad High Court observed that the evidence shows that the accused did not give any test dose to the deceased before administering the full dose of the injection. He did not claim that the injection was such that in all probability it could not have caused the allergic reaction and so the giving of a test dose of the injection was not necessary. The accused denied the very giving of injection which was proved beyond a shadow of doubt by the prosecution case. The
Court further ruled that the accused not being a qualified doctor, an injection given without the test dose and the immediate and subsequent death of the person so injected shows not only that the death was the direct consequence of administering the injection, but also that he acted with rashness, recklessness, negligence and indifference the consequences. It amounted to taking a hazard of such degree, that 1 injury was most likely to be occasioned thereby. So it was amply established that the accused caused the death of the deceased by doing the said rash and negligent act, which did not amount to culpable homicide. The accused was convicted by the trial Court under Section 304A, IPC to undergo sentence of one years' rigorous imprisonment (RI). The High Court observed that the appellant had been on bail and there being no allegation of any misuse of bail by him, the Court gave him the benefit of probation und Section 4 of the UP First Offenders Probation Act 1938 on furnishing, amount of Rs 4,000 with two securities in the like amount.

In Sukaroo Kobiraj Vs. The Empress\(^\text{336}\) herein a kobiraj with no regular education in medicine, operated upon a patient by cutting out his internal piles, but did not stop the consequent bleeding, which resulted in death of the patient. The Court observed that the prisoner was uneducated in matters of surgery and had no regular education in matters of medicine. He acted, as ' thought, for the benefit of the patient. But the prisoner is not entitled to benefit of Section 88 IPC. A patient can hardly be said to accept a risk which he is not aware. It was for the defence pleading the exception, to show, that the patient in the present case did accept the risk, and that consequently he was aware of it. But no attempt was made to show that the patient did know the risk he was undertaking. The evidence is only to the extent that he consented to the operation with great unwillingness, and that the only information communicated to him on the subject by the prisoner was that, if he submitted to the operation he would be cured. Upon that understanding, did he submit and

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\(^{336}\) (1877) 1LR 14 Cal 566.
consequently died. It seems that it is quite impossible' to say that he accepted the risk of the prisoner's act. The Court ruled that he caused the death of the deceased by his act. In England, he would have been indicted for manslaughter. In this country, the provisions of Section 304A seem to apply to cases where there is no intention to cause death, and no knowledge that the act done in all probability would cause death. The Court ruled that it was impossible to acquit him of the offence of which he has been convicted, so the conviction was confirmed. But it is not necessary for the ends of justice to sustain the severe sentence passed upon the prisoner. The Court further held, that the sentence of one year imprisonment would, therefore, be set aside, and a fine of Rs 100 was imposed upon the prisoner. In default of payment, he must suffer three months rigorous imprisonment.

In *Dr Khusaldas Pammandas Vs. State of Madhya Pradesh*337 a hakim registered under the Madhya Bharat Indian Medicine Act 1952, advised and administered a procaine penicillin injection to the patient without the knowledge or study of penicillin treatment, resulting in the death of the patient. The Court while dealing with the issue held that it does not matter whether he was a registered or unregistered hakim. The question is whether, to have any knowledge of penicillin treatment, the precautions to be taken before giving such an injection and the remedies that should be applied for combating any adverse reaction to the injection. It is the petitioner's ignorance of the knowledge that makes his act rash and negligent. The Court, while confirming the conviction of the petitioner, observed that no doubt hakims and vaidyas are legitimately entitled to exercise their profession for which they have been trained. But at the same time it is necessary that they should not dabble in medicines and treatments of which they have no knowledge whatsoever. It is very essential that the public, and especially the poorer part of the public, who very often rely upon such practitioners as hakims and vaidyas, should be protected from ignorant experiments of dangerous character.

Determination of Criminal Liability: The Court laid down the following principle while determining the criminal liability of the accused for rash and negligent acts. A doctor is not criminally responsible for a patient's death, unless his negligence or incompetence passed beyond a mere matter of compensation and showed such disregard for life and safety as to amount to a crime against the State. The degree of negligence required is that it should be gross, and neither a jury nor a Court can transform negligence of a lesser degree into gross negligence merely by giving it that appellation. Care should be taken before imputing criminal negligence to a professional man acting in the course of his profession. In a case where a doctor was charged with criminal negligence, in order to show that a particular injection given by the doctor was too strong, and to rebut the presumption that the death of a particular boy was due to an exceptional reaction to that injection, the prosecution tendered evidence of the symptoms, illness and death of nine other children\textsuperscript{338}.

A patient can hardly be said to accept a risk of which he is not aware. It was further observed by the Court that the public, especially the poorer part of the public, who mostly have to rely upon such practitioners as kobirajes, should be protected from ignorant experiments in surgery\textsuperscript{339}. Where a practitioner is utterly ignorant of the science of medicine or practice of surgery, then a favorable view of his conduct in giving any treatment prescribed in that science cannot be taken and his ignorance alone would make his act of giving treatment rash and negligent. The question is whether a hakim had any knowledge of penicillin treatment, of the precautions to be taken before giving a penicillin injection and of the methods of counter-acting any adverse reaction of the injection as a hakimme clearly has no occasion to make a study of penicillin injection or for the matter of that of any injection given in allopathic treatment. It was further observed that their Lordships in another case did not accept the view that criminal negligence was proved merely because a number persons

\textsuperscript{338} John Oni Akerele Vs. The King (Lord fortci) A.I.R. 1943 PC 72.
\textsuperscript{339} Sukaroo Kobimj Vs. The Empress (1877) TLR 14 Cal 569.
were made gravely ill after receiving an injection of sobita from the appellant, coupled with a finding that a high degree of care was not exercised\textsuperscript{340}. A person is guilty of gross negligence when he gives medical treatment for which he is unqualified. It was observed in Dr Khushaldas' Case. Where a practitioner is utterly ignorant of the science of medicine or practice of surgery, then a favorable view of his conduct in giving any treatment prescribed in that science cannot be taken. His ignorance alone would make his act of giving treatment rash and negligent\textsuperscript{341}.

**Doctor's Responsibility to Provide Medical Aid and Their Protection:**

There is no legal impediment for a hospital or medical professional when called upon or requested to attend to an injured person needing medical assistance immediately. This duty is shared equally by the police, connected persons and those who see such an incident or accident. The primary duty of the hospital and medical practitioner is to save the life of the injured in case of an emergency\textsuperscript{342}.

- A review of the decided cases reveal that under the Indian Penal Code very few cases have been filed against doctors due to various reasons. In some of the cases the Courts have shown their full sympathy towards doctors and imposed minor sentences for killing patients with their rash and negligent acts. Cases can even be cited wherein the Court has converted the sentence of one year's imprisonment awarded by a trial Court to a fine of Rs 100/-.

Further a provision has been made under *Section 357* of the Code of Criminal Procedure for awarding compensation. The judiciary has very sparingly uses this provision. The applicability of these provisions and the large number of acquittals and minimum sentences awarded in cases is an indication of the necessity to sensitis police officials as well as the judiciary. Further, there is a need

\textsuperscript{340} John Oni Akercle Vs. The King A.I.R. 1943 PC 72.

\textsuperscript{341} A.I.R.1960 MP 50.

to award severe punishment to those who in the guise of doctors with fake degrees resort to rash and negligent acts resulting in the death of innocent patients. This is necessary to discourage the increasing number of 'quacks' practicing allopathic and other systems of medicine.

- There is a fear in the minds of doctors/medical professionals that they may be harassed by police or even in the Courts of law particularly in medico-legal cases. This inhibits them in handling medico-legal cases. The judiciary and police should as far as possible avoid summoning medical professionals for interrogation. Therefore, there is a need to evolve certain guidelines and sensitize the police and medical professionals about the judgments of the Apex Court in this context.

- Separate provisions should be incorporated in the Indian Penal Code to deal with the offences committed by the medical professionals, since these offences are distinct from other offences and require special attention. This will create awareness among doctors and police officials and help in prevention of rash and negligent acts by these professionals.

*The 'Bolam' test electro convulsive therapy:* Mr. Bolam was advised electro convulsive therapy for mental illness. He was however, not warned of the risks of fractures involved in the treatment. There were two bodies of opinion. One preferred the use of relaxant drugs. Using relaxants, the patient sustained dislocation of both hip joints with fracture of pelvis. The doctor was not held negligent because he acted in accordance with practice accepted as proper by a responsible body of medical men skilled in that art. The 'Bolam' principle implies that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. It has been accepted by House of Lords as applicable not only to diagnosis and treatment but also to advice and warning. A doctor is not liable for taking one choice out
of two for favoring one school rather than another. He is only liable when he falls below the standard of a reasonable component practitioner in this field, so much so that his conduct may deserve censure. The complainant alleged that during operation for left inguinal hernia his left testis was removed negligently and without consent. On account of this suffered and has become handicapped. The State Commission on the basis of evidence placed on record, and opinion of expert witness held that the removal of testis was done of expert witness held that the removal of testis was done to avoid gangrenous infection, operation was done with reasonable care and skill and had not resulted in any handicap. Complainant was held to be vexatious and complainant liable to pay cost of 1st opposite party. The complainant was operated for gall stones, but subsequently he developed stricture near the bulbous urethra due to which he could not enjoy sex and could not pass urine easily. He ultimately had to be operated at a Urological Hospital for relief and heavy amount had to be spent due to negligent performance of his first operation. The State Commission observed as under and the complaint was dismissed. “There is absolutely no evidence to establish that there was any negligence on the part of the opponent in performing the operation o July 30, 1992 and that it was a result of such negligence that second operation became necessary on account of negligence in performance of first operation.

There is no certificate of the doctor of Urological hospital at Nadiad wherein it is alleged to have been stated that second operation became necessary on account of first operation on record. In absence of any expert evidence, we cannot hold the opponent guilty of negligence in performance of the first operation. We also do not see any reason to disbelieve the statement made on oath by the opponent who has not been cross-examined. The opponent stated that he had performed the operation on the complainant carefully and that the complainant had not complained of pain when he was discharged from the

343 Tarun Kumar Pramanik Vs. Dr. Kunal Chakraborty and Ors.,
344 Jayantilal Govindlal Parmar Vs. Managing Trustee and Ors,
hospital and thereafter. There is also some force in the opponent’s submissions that if the complainant was suffering from intense pain as alleged by him, he would not have waited for seven months to consult Dr. Rajaguru. There is nothing in the documentary evidence place on record which should support the allegations made by the complainant”.

**Removal of testes:** The complainant was operated for hernia and fistula by the opposite party. It was alleged that during surgery the opposite party removed his left testis along with its blood vessel without consent. The State Commission held that the case papers of the complainant reflected that the wound had healed well. Also, the consent very clearly mentioned the permission for removal of testis. The operation conducted subsequently by Dr. Parikh was for some other problem and not for any defect in the surgery conducted by the opposite party. The complainant had also not cared to get expert witness of Dr. Parikh or any other expert witness, through he had enough time and opportunities 345.

**Prostate biopsy:** In the case of *Pyare Lal Verma Vs. Dr. A.K. Gupta and Ors.*, The complainant, aged 72 years was advised surgery enlarged prostate by the opposite party. He was referred to Dr. Neeraj Nagpal, MD to opine about fitness to undergo surgery, who however, after necessary tests opined that there was no active contraindication for TUR surgery. After surgery, the prostate gland pieces removed were sent for biopsy report to Dr. Mrs. B.K. Aikat, who stated that there was benign hyperplasia of the prostate and no malignancy was seen. Subsequently, the complainant developed complications and after 6 months during review of the biopsy slides at the PGI it was discovered that the prostate was cancerous. The Commission held that there is nothing whatsoever to indicate Dr. Nagpal’s pre-operative opinion was palpably wrong or patently negligent. It was also conceded before the Commission that there inevitably would be chemical changes in the slides by 345 Harjivanbhai Khoda Bhai Gohil Vs. Dr. Yogendra D Shah
the mere passage of time and dependent on the manner and method by which they were preserved, if at all. The Commission also held that a variation of exert medical opinion cannot be labelled as negligence.

**Amputation of penis:** In the case of *C. Sivakumar Vs. Dr. Jalin Arthur and Anr* the complainant, a 23 years old boy approached Dr. John for blockage in passage or urine i.e., phimotic penis who took him another clinic for operation. After the operation there was over-bleeding from the penis and ultimately he was admitted to Jipmer Hospital. The hospital authorities reported the matter to the police. Here he came to know that his penis had been cut off (amputated) and only a small stump had been left, and he was passing urine only through an artificial hole made at Jipmer Hospital. He, in the process, had become permanently impotent. Compensation of Rs.8 lakhs was awarded to be paid by the first opposite party.

**Torsion Testis:** Negligence in diagnosis and treatment of a case of torsion testis as 'orchitis leading to gangrene of the testis. The commission held that mistaking torsion for orchids in itself does not constitute negligence because the symptoms of the two mimic each other. There was also evidence that the patient was suffering from the disease for 4 to 5 days prior to admission and as such performing surgery would still not have saved the testis. The complaint was dismissed.

**Chronic Renal Failure:** Alleged negligence in a case of chronic renal failure requiring kidney transplantation who has infection in thigh at the site of veinflon insertion through which dialysis was repeatedly being performed. There was an arterio venous fistula formation and gangrene leading to amputation of the leg and later death. The opposite did not appear in Court. Allegations made by the complainant were duly supported by the sworn affidavit of the expert witness Dr. Prakash Tathed who has an extensive experience in this field. A compensation of Rupees two lakhs was allowed. A physician can be charged with criminal negligence when a patient dies from the
effects of anesthesia during, an operation or other kind of treatment, if it can be proved that the death was the result if malicious intention, or gross negligence. Before the administration of anesthesia or performance of an operation, the medical man is expected to follow the accepted precautions. In such cases, the physician should be able to prove that he used reasonable and ordinary care in the treatment of his patient to the best of his judgment. He is, however, not liable for an error judgment. The law expects a duly qualified physician to use that degree of skill and care which an average man of his qualifications ought to have, and does not expect him to bring the highest possible degree of skill in the treatment of his patients, or to be able to guarantee cures.

It has long been recognized that criminal liability of a physician may result from a high degree of negligent conduct. What the law calls criminal negligence is largely a matter of degree; it is incapable of a precise definition. To prove whether or not it exists is like chasing a mirage. It requires that any of the following to be established in a case of criminal medical negligence. "Gross Lack of competency or gross inattention, or wanton indifferences to the patient’s safety, which may arise from gross ignorance of the science of medicine and surgery or through gross negligence, either in the application and selection of remedies, lack of proper skill in the use of instruments and failure to give proper attention to the patient.” (Hampton v State; State v Lester)

In R.V. Bateman (1925), Dr. Bateman was prosecuted for manslaughter and the charges of negligence made against him were:

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

The trial Court convicted him. But the Court of Appeal held in order to establish criminal liability, the facts must be such that, the negligence of the accused went beyond a mere matter of compensation among subjects and
should such disregard for the life and safety of others as to amount to a crime against the state and conduct punishment.” When a FIR (First Information Report) is filed against a doctor for the death of a patient who was under his treatment, under this Indian Penal Code Section 304-A the doctor can be arrested. A doctor charged under this Section can obtain bail and if proved guilty, the doctor can be punished with a maximum of two years imprisonment or fine or both. But, if the patient is alive, the doctor is charged under the Indian Penal Code Section 337 and 338. The Indian Courts have been very careful not to hold qualified physicians criminally (instances of quacks for criminal negligence are there) liable for patients’ deaths that are the result of a mere mistake of judgment in the selection and application of remedies and when the death resulted merely from an error of judgment or an inadvertent death.

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

4.6. Trends in Judicial Outcomes and Consequences for Health Care

But it must be borne in mind that there are a relatively smaller numbers of employees governed by health care legislation in the private sector. Besides, in recent times the attitude of the courts towards these employees has not been very positive. For instance, recently the Supreme Court held that a casual workman is not covered under the Workman’s Compensation Act. The second branches of litigation concerning employees are cases regarding government servants. A large number of these cases pertain to the rights of government employees to reimbursement of medical expenses incurred in private health care sector. At around this time patients started approaching the courts in matters concerning medical negligence. They were required to file suits in the district courts, which were highly time consuming, expensive and in many cases resulted in failure. The law followed in these matters was the English common law (judge made law) concerning torts and more particularly negligence. Though the legal tools to fight against medical negligence have always been available, the procedural tools were highly inadequate. So the cases were few.

This situation changed dramatically from the mid 1980s with the passage of the Consumer Protection Act and a consequent decision of the Supreme Court that medical services (except those providing totally free medical services) were covered under the Act. On matters of negligence the development of litigation has been quite phenomenal. Of course, the legal principles on this issue remain the same as they were more than 50 years ago. It is necessary to show duty to take care; it is important to point out the standard
of care required; and, it is crucial to establish the linkage between negligence and injury. Even so, the courts have started utilizing some recently derived principles such as informed consent. On the other hand, the Supreme Court in recent times has whittled down criminal responsibility of doctors by holding that doctors could not be held criminally liable unless they are guilty of 'gross' negligence. Besides, police complaints cannot be filed without another doctor's opinion concerning negligence. Such opinions are very difficult to obtain. Although victims of medical negligence have the option of also approaching medical councils, their experience, with these Councils has, by and large, been negative. The general feeling is that medical councils are overprotective of doctors. Drugs and Cosmetics Laws have been existence since before independence. Judicial decisions under these laws have been mainly in respect of licensing conditions and classification of various items as drugs. The courts have not often interfered with the strict licensing conditions concerning drug manufacture, storage and distribution. They have also given a broad definition to the term 'drug' preventing escape route for manufacturers from strict quality control. The next decade, will of course witness gruelling battles on drug patents. With product patents being now available coupled with strategic ever greening of patents by large pharma industries there are likely to be pitched legal battles between patient rights groups, state and the industry.

In recent years there has also been a large amount of litigation concerning the right to practice medicines by people holding qualifications not recognized under the law. Since the 1980s with the rapid privatisation of medical education many unaffiliated, unrecognised colleges have cropped up offering diplomas and degrees in branches of medicines not recognised under the law. Instances of these are electropathy and electro homeopathy. Gullible students take these courses paying high fees only to realise later that these qualifications have not been duly recognised by any authority. The courts have consistently refused to interfere in these matters and have disallowed such persons from practising medicine. However, the courts have acknowledged the
The 1990s saw litigation in two new branches of health care law. First has been in respect of the law concerning HIV/AIDS. Though as yet there has been no central law relating to this, the courts have intervened in matters concerning the rights of HIV positive persons especially in employment related laws and through the use of the right to life to include the right to live with human dignity. The development in this area of law has been very interesting. In the 1980s when there was little awareness about this issue, the courts were inclined to focus on protecting society from HIV positive persons. But in the 1990s with a growing understanding of the issue the courts have stepped in to protect the confidentiality of positive persons, prevent discrimination in employment and other aspects of life. In the next few years, we are likely to witness a proliferation of litigation concerning this branch of law, especially if the new law in the making rolls out. Similarly, after the enactment of the Organ Transplantation Act in the 1990s some amount of litigation emerged on the issue.

The litigation till now has been around the issue of who can donate organs. But as cadaver transplantation becomes more popular, a plethora of issues under this law are likely to arise. Euthanasia is not recognised in India. However, debates have started on this issue and one can foresee some litigation on this controversial issue. Another area where perspectives have hanged over a period concerns mental health. From treating mentally ill patients as those who deserve to be locked up and forgotten the perspective now is much more sensitive and favourable to them. This is also reflected in the Disabilities Act passed in the 1990s. Earlier the law as well as litigation concerned rights vis a vis the mentally ill. Now it is increasingly tending to be a perspective of the rights of disabled persons. Even so, the main area of litigation in this branch has been around conditions of homes for the mentally ill and their confinement in prisons. However, with the passage of time and more awareness of the
complexities of the problem courts are likely to be more frequently approached. Women’s health as a separate subject was always recognised through various provisions in the Factories Act, laws concerning abortion and the Maternity Benefit Act. But the special importance of women’s reproductive rights emerged in the 1980s after struggles of women’s groups on the use of women as guinea pigs for testing contraceptives. The courts have been called upon to restrain such experiments. The courts have been approached for failure of sterilization operations but in these matters they have, by and large, refrained from interfering. In the only case relating the Right to Food currently pending in the Supreme Court\(^ {346} \), the Court has been satisfied with giving certain directions so as to see that people do not die for the want of food. He Right to Food includes the Right to Health and Health-care and it is not merely the right to receive food in terms of minimum calories, but, it includes the Right to Adequate Food. The adequacy will then be measured by not only what is necessary for survival, but by a person’s health or by his ability to pursue a normal active existence. The concept of adequate food for the maintenance of health, not only requires a minimum calorific intake but also a certain balance of nutrients. The Right to Food should be understood together with a range of other rights – access to health care, medical facilities, drinking water and sanitary facilities. Unfortunately, the Supreme Court has not yet laid down the inter-relationship between Right to Food and Right to Health.

**Public Interest Litigation, Fundamental Right and its Consequences**

Two developments in the 1980s led to a marked increase in health related litigation. First was the establishment of consumer courts making the suing of doctors and hospitals for medical negligence and deficiency in service easier and cheaper. Second was the growth of public interest litigation, an expanded interpretation of the Right to Life as a fundamental right and one of its off shoots being the recognition of health and health care as a fundamental right. The public interest litigation movement in India began in late 1970s. Its

\(^{346}\) P. U. C. L. vs. State of W. B. & Ors.
foundation is the enforcement of fundamental rights guaranteed under the Constitution of India. Any citizen could trigger off the judicial mechanism by claiming a violation of Fundamental Rights, either of himself for of other individuals or of the citizenry at large. Fundamental Rights existed even before the late 1970s. The real push for the PIL movement came from an expanded interpretation of the Fundamental Right to Life which is enshrined in Article 21 of the Constitution. This reads: No person shall be deprived of his life or personal liberty except through procedure established by law. Till the 1970s, by and large, the courts had interpreted ‘life’ literally i.e. right to exist. The late 1970s onwards an expanded meaning started to be given to the word ‘life’. Over the years it has come to be accepted that life does not only mean merely animal existence but the life of a dignified human being with all its concomitant attributes. This has been interpreted to include a healthy environment and effective health care facilities. As we have seen in earlier Chapters to begin with, the right to health as a fundamental right grew as an off shoot of environmental litigation. Pollution free environment as a fundamental right presupposes the right to health as a Fundamental Right. Logically, the explicit recognition of the fundamental right to health should have preceded the fundamental right to good environment. However, the development of jurisprudence in this branch has been the reverse. To begin with, the right to decent environment was recognised and from that followed the right to public health, health and health care. Even while dealing directly with the right to health, the first issues concerned employees’ health within a work place.

It was only in 1991, in *C.E.S.C. Ltd. vs. Subhash Chandra*\(^{347}\) that the Supreme Court placed reliance on international instruments and declared that the right to health was a fundamental right. The question, however remains whether a particular right is a positive or a negative right. A negative right is one which does not require the State to take any positive steps for its realization but only needs the State to ensure that no actions are taken that deprive the

\(^{347}\) AIR 1992 SC 573

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person of the right. For instance, a negative right to health would mean that the state should ensure that there is no pollution or that the drugs supplied by companies are of good quality. On the other hand, a positive right would mean that the State should build hospitals, ensure provision of drugs at cheap rates, etc. While the Supreme Court has on occasion implicitly held that the right to health was a positive right, on most occasions its treatment has been as a negative right. In Vincent Panikurlangara Vs. Union of India\textsuperscript{348}, the Supreme Court observed "In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health.” Because of having recognized that right to health and health care as a fundamental right what follows? Fundamental rights are generally available only against the state. They prescribe the obligations of the State. In a poverty ridden country like India, does it mean that the State must provide free medical health care facilities to all? In a situation where there is increasing privatisation of the health care systems, where the proportional annual budget for health is shrinking, where the cost of health education is growing exponentially this seems very unlikely. No court has yet said that the State is bound to provide free medical care to all the citizens. This would be the consequence if the right to health care was recognised as a positive right.

The other aspect would, of course, be the quality of health care provided by the State. Infrastructure does not just comprise primary health care centres but even in government run hospitals in metropolitan cities service is crumbling. These institutions are plagued by a lack of enough beds, sufficient medicines and other similar problems. The Courts including the Supreme Court have not adequately dealt with this aspect. They have mainly been concerned with pious declarations of health being a fundamental right and peripheral and not so peripheral issues such as the rights of government employees to be treated in government hospitals, emergency medical care and the like. Even in respect of emergency health care, the private sector has not yet come within the

\textsuperscript{348} AIR 1987 SC 990 (1987) 2 SCC 165
sweep of the Courts. In the case of *Paschim Banga Khet Mazdoor Samiti vs. State of W.B.*, the Supreme Court observed that providing adequate medical facilities was an essential part of the obligation undertaken by the State in a welfare state. And failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in the violation of his right to life guaranteed under Article 21. Although the responsibility of the State and government hospitals is well provided by a radical interpretation of the Constitution, there is no definite corresponding legal duty imposed on private hospitals and practitioners to treat emergency cases. The judgments mainly focus on the duty of the State and the government hospitals. Of course, in respect of medico legal cases, the Supreme Court has held that doctors are obliged to treat medico legal patients in without insisting on prior paper work in both private and public sector. The Supreme Court and the high courts have been intervening in a much more active manner in the last few years on the issue of health and health care. But again, unless they start looking into the impact of patents and drug price control as also the obligations of private hospitals, the effect is bound to be limited. The Bombay and Delhi High Courts have already started looking into this issue, but unless there is a national level focus on the responsibilities of private health care providers the impact of judicial decisions is likely to be only marginal. It is time that private hospitals were made amenable to writ jurisdiction of high courts and the Supreme Court. This is crucial because individuals and groups can then approach the high court and Supreme Court directly regarding their grievances.

They can claim that even private hospitals are subject to fundamental rights and liable for various social obligations concerning health care. Education, even in the private sector is held so susceptible. The Supreme Court has held that education is a sovereign function and even when it is being carried out in the private sphere it is a mere extension of the sovereign function and thus bound by various State mandates. There is no reason why health care

349 (1996) 4 SCC 37
should not be treated similarly as a sovereign function and the private sector seen as an extension of the State and thus subject to fulfilling its obligation towards the citizens. In the coming decades a number of issues that will have a significant impact on the right to health and health care are likely to arise. Some of them are as follows:

- Interpretation and implementation of the new patent regime and its impact on availability and pricing of drugs
- Obligation of private hospitals towards poor persons
- Reducing role of the state sector in providing health care and its impact on the fundamental right to health care
- The shrinking regime of Drug Price Controls  Legality of Euthanasia
- Conditions of public health care institutions including hospitals and primary health care centre

In the last 15 years there has been a major proliferation of litigation especially in the higher courts on health care issues of diverse varieties. Health and health care have been recognised as fundamental rights but the significance and implications of this recognition are yet to unfold. The next few years will be the testing time for the judiciary because if the right to health care has to be recognised and realised in a meaningful way the courts will have to clearly spell out the obligations of the State in providing health care facilities and will also have to bring within their net private health care providers as well as the powerful pharma industry. Health is a social, economic and political issue and above all a human right. Inequity and poverty are the root cause of ill health leading to malnutrition and starvation deaths in the marginalized sections of the society. The current health scenario favours the urban affluent class, which is only about 10 per cent of the total population. There is a need to remove regional imbalances. Declining health expenditures have adversely affected health outcomes worsening the health scenario. There is a need to restructure the existing health system. The highly privatised health system has deprived the
masses of even primary health care leading to out-of-pocket expenditure, which they can ill afford. The National Health Policies did not achieve their targets thus creating a need for a comprehensive legislative framework. The existing health system needs to be restructured to usher equity and social justice. This can be achieved through the promulgation of a comprehensive legislative framework, which should create conditions conducive to restoring balance in the health sector. The legislation should be complemented by making the ‘Right to Health Care’ a fundamental right, which will be an enforceable right. The ultimate aim of Universal Access to Health Care could be achieved through the restructuring of health finance and the introduction of universal coverage of health care.

4.6.1. National Human Rights Commission

There are different ways of protecting human rights. A pluralist and accountable parliament, an executive that is ultimately subject to the authority of elected representatives and an independent, impartial judiciary are all necessary, but not sufficient, institutional prerequisites [Burdekin and Anne Gallagher, 1998]. Besides these basic ‘institutions’ there are other mechanisms whose establishment and strengthening will enhance the existing mechanisms. In this chapter look at the National Human Rights Commission as an alternative way of protecting human rights. Although Andhra Pradesh, Assam, Himachal Pradesh, Jammu & Kashmir, Kerala, Madhya Pradesh, Maharashtra, Manipur, Orissa, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh, West Bengal, Chattisgarh and Gujarat all have their own state human rights commission each we could not focus on them due to non-availability of cases.

- What is the National Human Rights Commission (NHRC)
- To what extent can NHRC help in making the government accountable
- Is NHRC in India effective in protecting human rights

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NHRC can establish a culture of accountability as it is charged with monitoring the state's performance constantly. Without effective monitoring, states cannot be held accountable for non-implementation of, or be made liable for, violation of human rights. Of course, this monitoring work can be done to a certain extent through the judiciary but the NHRC has the potential to accomplish this task more effectively. It has to be proactive without being Confrontational, so that public interest does not suffer because of unnecessary and unproductive competitiveness with other governmental bodies. It has to take the initiative rather than have a prescriptive view. NHRC India was the first National Human Rights institution to be established in South Asia. Its record has not been completely uncontroversial in its decade-long existence but it has taken tough and independent stands on several occasions. Despite its weak foundation, NHRC (India) is effective and demonstrates that human rights protection does not have to rely entirely on the courts. Gradually it has become locus of human rights awareness at the national level.

**Mandate**

NHRC India has limited mandatory powers. The Human Rights Protection Act, 1993 takes a very narrow view of human rights and provides that 'human rights' means the right relating to life, liberty, equality and dignity of the individual guaranteed by the Constitution of India or embodied in the International covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (ICESCR) and enforceable by the courts in India. So, the main drawback of this statutory definition seems to be that it curtails the mandate of the commission by limiting it to the rights enshrined in the two covenants and the Constitution. As India subscribes to the dualist pattern with regard to the relationship between international treaty law and domestic law, theoretically speaking the commission cannot discharge its responsibility for protecting rights in the covenants unless the Parliament enacts domestic legislation incorporating these rights. While the Supreme Court has reiterated this dualist approach to enforcement of international treaty law in
India\textsuperscript{350}, lately it has dealt with this issue differently. Besides this India has signed several other International treaties but due to this limited definition NHRC's mandate is restricted to the two covenants alone. But this factor does not diminish the magnitude of its task or its potential to protect India's citizens and to develop a culture respectful of human rights and fundamental freedoms.

**Composition**

The Human Rights Act, 1993 sets out the legal framework of the NHRC. The composition of NHRC is high-powered as three out of its five members are judges. The chairpersons of the National Commission for Minorities, the National Commission for the Scheduled Castes and Scheduled Tribes (SCST) and the National Commission for Women are all deemed (ex-officio) members of the commission. The remaining two members must be men and women "who have knowledge and practical experience in matters relating to human rights".

**Powers**

By holding the government accountable for existing or past violations of human rights, the NHRC can play a vital role in fulfillment of national and international human rights norms. It accepts complaints regarding human rights violations and asks for explanations from the government. If it is not satisfied with the reply, it starts an independent investigation, in the course of which, the commission among other things can summon and force witnesses to appear before it and then examine them under oath. It can also call for relevant documents. In its proceedings; the NHRC is endowed with all the powers of a civil court.\textsuperscript{351} Sometimes the NHRC initiates a general public inquiry also.

\textsuperscript{350} Jolly George vs. Bank of Cochin, AIR 1980 SC 470(where the Supreme Court held that rights contained in an international treaty that India has signed do not become a part of the corpus juris of India until parliament makes implementing legislation incorporating those rights as quoted in Sripati Vijayshri, 'India's National Human Rights Commission: Strengths and Weaknesses', in Lindsnaes Birgit, Lindholt Lone & Yigen Kristine (edit.), 'National Human Rights Institutions: Articles and Working Papers', The Danish Centre for Human Rights, 2001,p.157

\textsuperscript{351} NHRC's Annual Report, 1996-1997
Following investigation, the NHRC can award compensation or can issue directions. It has been successful sometimes, in persuading the state to pay compensation to victims of human rights violation. It can also recommend the granting of ‘immediate interim relief’ to a victim of human rights abuse or to his or her relative.

**Suo Moto Powers**

The commission can receive complaints or investigate on its own about ‘violation of human rights or abetment thereof or negligence in the prevention of human rights violations by public servants’. These powers to initiate suo moto inquiries are an important aspect of its protective functions that can be fully utilised. This is particularly relevant in those situations, which involve individuals or groups belonging to the marginalised sections of society who do not have the financial or social resources to lodge individual complaints. It is these vulnerable groups, which are the ones most likely to be unaware of their rights and of the Mechanisms, which protect these rights. The Commission has taken cognisance of many news reports here and those by foreign news agencies. NHRC has adopted a proactive approach in the area of Economic, social and cultural rights. The commission has taken the issue of starvation deaths in the state of Orissa very seriously. With the help of its Special Rapporteur, the commission has been monitoring the situation on a continuing basis. In this matter it has taken the view that the Right to Food is inherent to a life with dignity, and Article 21 of the Constitution of India which guarantees the fundamental right to life and personal liberty should be read with Articles 39(a) and 47 to understand the nature of the obligations of the State in order to ensure the effective realisation of this right.

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352 The Protection of Human Rights Act, 1993, 12(a)
353 Special Rapporteur is a title given to individuals working on behalf of the United Nations who bear a specific mandate from the former UN Commission on Human Rights to investigate, monitor and recommend solutions to human rights problems
354 Article 39(a) of the Constitution, enunciated as one of the Directive Principles, fundamental in the governance of the country, requires the State to direct its policies towards securing that all its citizens have the right to an adequate means of livelihood

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The other important issues that NHRC has been concerned with are issues relating to HIV/AIDS and human rights. These include: consent and testing, confidentiality, discrimination in health care, discrimination in employment, women in vulnerable environments, children and young people, people living with or affected by HIV/AIDS and marginalized populations. After taking suo motu cognizance of the calamity arising from the devastating earthquake, which hit large areas in the state of Gujarat in 2001, NHRC constantly monitored the relief and rehabilitation measures undertaken by the government in the earthquake hit areas. The commission drew the attention of the government to the fact that the official machinery involved in rehabilitation should be able to take all the steps necessary for the equitable distribution of both relief as well as rehabilitation measures and that in the process, the poor, destitute women and children and old persons, who would be in greater need of relief and rehabilitation assistance, should not be deprived or made to suffer. NHRC also follows up of public-spirited judgments of the Supreme Court of India. Indeed, in important instances, the Supreme Court has itself remitted to the commission matters that were before it. Notable among them are the cases relating to the allegation of starvation death in Orissa, the monitoring of programmes to end bonded and child labour, the mass cremation of unidentified people of Punjab and the proper management of institutions for the mentally challenged and protective home for women.

A symbiotic relationship exists between the NHRC and the Supreme Court and the latter emphasized that the commission can bring sustained scrutiny on these matters. NHRC is mandated under Section 12 of the Protection of Human Rights Act, 1993 to visit government-run mental hospitals and study the living conditions of the inmates and make recommendations thereon. The most notable intervention of the NHRC in mental health has been a project on Quality Assurance in Mental Health:

Article 47 spells out the duty of the State to raise the level of nutrition and standard of living of its people as a primary responsibility.
launched in 1997 to analyse the conditions generally prevailing in government-run mental hospitals in various parts of the country with reference to infrastructure, patient care, admission, discharge and appeal procedure, rehabilitation facilities, client satisfaction and morale of the staff. The project report ‘Quality Assurance in Mental Health’, with comprehensive recommendations was circulated by the commission to the health secretaries of all the States and UTs.

**Important Judgements**

The most infamous case is that of Ajoy Ghose who spent 37 years in jail till November 1999. Arrested for killing his brother in 1962, he was subsequently certified as insane. While he was in prison, the trial judge and all the witnesses died. His mother too expired after which he passed through serious emotional upheaval. And since he was legally declared a lunatic, he was not tried. It was under the initiative of the then Chief Justice of India and now NHRC chairman, Justice A.S. An, that he was shifted from Kolkata’s Presidency Jail to a Missionaries of Charity home. The Punjab and Haryana High Court has accepted in to NHRC’s recommendations for mentally challenged prisoners languishing in the jails of the two states. The decision came in November 2006, while hearing the case of one Jai Singh, a mentally challenged person, who had died in prison after spending almost 30 years there as an under trial (NHRC Annual Report, 2003-04).

In September 2004, NHRC had filed intervention application for impleading it as a party, in the Punjab and Haryana High Court to assist in the pending civil writ petition in the case of mentally ill under trials in jails. It took this decision while pursuing the case of Jai Singh, who had been in custody as an under trial prisoner in the Ambala Central Jail for nearly 27 years. This case came to the notice of the commission when the chairperson Justice A.S. Anand visited the jail in October-2003. Soon the commission sought reports from the superintendent, Mental Hospital Amritsar, Superintendent, Central Jail Ambala,
DIG Ambala Range and Addl. Sessions Judge Kurukshetra. Jai Singh, who was sent to Ambala jail in September 1976 on murder charges, was later transferred to the mental hospital in Amritsar in May 1979 for treatment, and thereafter never produced in the trial court. A careful perusal of the various reports received by the commission projected a rather distressing picture. Jai Singh’s case file had been consigned to the record room with the direction that the case would be summoned as and when the accused was fit to face trial. Medical reports appeared to have been sent to the court only intermittently. It appeared that Jai Singh had been reduced to a number and forgotten. In November 2004 NHRC received a representation from Jai Singh’s wife as well, stating that she had been denied meetings with her husband. She prayed for his release on humanitarian grounds. While the case was still pending before the Punjab and Haryana High Court because of Jai Singh’s incapacity to face trial, the court was informed that the prisoner had died in jail in October 2005. The commission intervened in another case of one Charanjeet Singh, a mentally ill inmate of Tihar Jail, Delhi in March 2005. In this matter also the commission presented before the Delhi High Court guidelines to be followed in the case of mentally ill prisoners. The Delhi HC directed the government of NCT, Delhi to adopt the guidelines suggested and to chalk out a proper strategy to deal with such cases of mentally ill prisoners who are convicts or under trials. Following NHRC’s impleading in the Jai Singh’s case, the court also took note of 11 other mentally challenged persons. The court has asked the administration of the two states and the lower judiciary to follow the recommendations of the commission in to:

- Psychological or psychiatric counseling should be provided to prisoners as required in order to prevent mental illness and/or to ensure early detection. Collaborations of this purpose should be made with local psychiatric and medical institutions as well as with NGOs.

356 Writ Petition (C) 10791/2002
357 Writ Petition (Cr) 729/2002 and 1278/2004, decided on: 04.03.2005
• Central and District jails should have facilities for preliminary treatment of mental disorders. Sub-jails should take inmates with mental illness to visiting psychiatric facilities. All jails should be normally affiliated to a mental hospital.

• Every central and district prison should have the services of a qualified psychiatrist who should be assisted by a psychologist and a psychiatric social worker.

• Not a single mentally ill person who is not accused with committing a crime should be kept in or sent to prison. Such people should be taken for observation to the nearest psychiatric centre, or if that is not available to the Primary Health Centre.

• If an under trial or a convict undergoing sentence becomes mentally ill while in prison, the State has an affirmative responsibility to the under trial or convict. The State must provide adequate medical support. As such appropriate facilities should be provided in State assisted hospitals for under trials who become mentally ill in prison. The person should be placed under the observation of a psychiatrist who will diagnose, treat and manage the person. In case such places are not available, the State must pay for the same medical care in a private hospital. In either case care must be provided until recovery of the under trial/convict.

• When a convict has been admitted to a hospital for psychiatric care, upon completion of the period of his prison sentence, his status in all records of the prison and hospital should be recorded as that of a free person and he should continue to receive treatment as a free person.

• Mentally ill under trials should be sent to the nearest prison having the services of a psychiatrist and attached to a hospital, they should be
hospitalized as necessary. Each such under trial should be attended to by a psychiatrist who will send a periodic report to the Judge/Magistrate through the Superintendent of the prison regarding the condition of the individual and his fitness to stand trial. When the under trial recovers from mental illness, the psychiatrist shall certify him as 'fit to stand trial'.

- All those in a jail, with mental illness and under observation of a psychiatrist should be kept in one barrack.

- If a mentally ill person, after standing trial following recovery from the mental illness is declared guilty of the crime, he should undergo term in the prison. Such prisoners, after recovery should not be kept in the prison hospital but should remain in the association barracks with the normal inmates. The prison psychiatrist will, however, continue to periodically examine him for reviewing his treatment and suggesting him other activities.

- The State has a responsibility for the mental and physical health of those it imprisons.

Babu Lal, an under trial prisoner who was admitted in the District Jail, Banda with burn injuries was sent to the District Hospital, Banda under police escort. He died while undergoing treatment in the hospital on November 22, 2000. The Commission observed that the records showed that instead of taking prompt action to follow the advice of the surgeon of the District Hospital, Banda, the jail authorities entered into a bureaucratic tussle with the police authorities on the point as to who was responsible for providing guard (escort) and transport for taking the victim prisoner to Lucknow Medical College for treatment. The commission while looking into his case found a disturbing fact—despite repeated recommendations of the doctor first made, as early as
November 8, 2000, the patient was not shifted to the Medical College, Lucknow for specialized treatment. The authorities concerned kept exchanging correspondence for sorting out the issue of who would provide escort for shifting the patient from Banda to Lucknow. Because of this approach adopted by the authorities the patient could not be given proper medical treatment.

The commission expressed its anguish at the utter lack of sensitivity on the part of the prison authorities in handling Babu Lal’s case. The commission viewed it as a classic case of systemic failure resulting in a loss of life, which possibly could have been saved. It has stated that technical considerations for shifting a patient to the hospital cannot outweigh the right of the patient to proper health care and as such, his right to life. The commission emphasised that Right to Life was a basic human right guaranteed as fundamental right under the Constitution of India. Therefore, it is the obligation of every state functionary to protect the life of a detainee in his custody and ensure proper medical treatment for him or her as and when required. It also recommended that appropriate directions be issued to all concerned that whenever a human life is involved and the case is of urgent nature, prompt action for proper medical treatment of the detainees should be taken by the officials concerned.

4.7. Medical Negligence Cases

- Janadhikar, an NGO\(^{358}\) approached the commission with a news report stating that Smt. Bihalavati, wife of Ram Prakash was taken to the District Hospital, Siddharth Nagar for delivery and though she was experiencing acute labour pain, she was not admitted by the staff nurse as her husband had failed to pay Rs.250/- as demanded by the latter. She was admitted only after other persons paid the amount. At around 1 p.m. when her condition became very serious, a General Duty Medical Officer examined her and referred her to Gorakhpur but before she could

\(^{358}\) [http://nhrc.nic.in/dispArchive.asp?fno=1035](http://nhrc.nic.in/dispArchive.asp?fno=1035)
be taken to Gorakhpur, she expired. It had been alleged that Smt. Bihalavati died due to negligence and carelessness on the part of doctors of the District Hospital, Siddharth Nagar as her husband had failed to meet their illegal demand. The commission directed the Uttar Pradesh government to pay a sum of Rs.50,000/- by way of interim relief to the next of kin of Smt. Bihalavati who died on 12 August 1999 due to negligence and carelessness on the part of doctors of the District Hospital, Siddharth Nagar, Uttar Pradesh. The compensation was given by the state government.

- Smt. Ram Kumari in her complaint to the commission stated that her late husband, Shri Krishan Kumar, died in a road accident when his truck collided with a tree and caught fire thereafter. The police prepared an inquest report and sent the burnt body of her husband for post-mortem to Rai Bareilly. A team of three doctors performed the autopsy on 17 May 1998 but were unable to give an opinion on the cause and time of death and, therefore, sought the opinion of the state medicolegal expert. The opinion was delayed by six months, as a result of which the complainant was made to rush from Allahabad to Rai Bareilly to plead with the authorities to hand over the remains of her husband's dead body for performing the last rites. The complainant sought the commission's assistance in getting the dead body released early. From the reports, the commission noted that the bodily remains of the deceased were handed over to the complainant nine months after the death; this had resulted in mental agony to her and forced her to rush to Rai Bareilly to contact the authorities. It held that this avoidable delay was directly attributable to the gross negligence of the state authorities at different levels. In the circumstances, the commission recommended the payment of interim compensation of Rs.10,000 to the complainant by the government of Uttar Pradesh within two months that has since been paid.

359 Case No. 7122/24/98-99
• The Maharashtra State Human Rights Commission received a complaint regarding the death of one, Mala Bharat Jadhav, during a sterilisation operation. The commission took cognisance, as a result of which, on the finding recorded by quality assurance committee headed by Dr. K. S. Bhise, Deputy Director of Health Services, Akola, the husband of the deceased was recommended compensation of Rs. 40,000, even though it was not a case of medical negligence.

• In a compliant by chairman Social Welfare Council, Nayagarh, Orissa informed the Commission that one Mr Sethi was bitten by a stray dog and he went to the District Hospital Nayagarh for free shots of the vaccine. But in the hospital rabies vaccine was not preserved in cold storage. He received anti-rabies injections on his stomach for seven days, but because of an adverse reaction to the vaccine, he developed partial paralysis and malfunctioning of a kidney. He had no means to undergo treatment in a private hospital and was fighting for his life. The complainant prayed for an independent inquiry into the negligence of the medical personnel of the hospital and adequate compensation for maintenance and treatment of the patient. The commission conducted inquiry and directed department of family and health to pay a compensation of Rs. 2 lakh for further treatment.

• In a case of medical negligence, which came to MSHRC. The complainant, Siva Salian, advocate was not allowed to see his wife who was admitted in KEM Hospital on January 1, 2001 due for a breathing problem. Three days after her admission her condition was reported to be critical. She died on January 23 at 6:20 a.m. The complainant made two allegations. Firstly, the doctor-in-charge refused to allow the

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360 Case No. 2002/2002 : Order dt. 4/4/03
361 Case No. 109/01: Order dt.19/05/04
complainant and his younger daughter Dr. Supriya to see the patient even when she was in a critical condition, and second though the patient desired to see her husband and daughters while she was in the ICU, they were not allowed to do so. They alleged that there had been violation of the human rights. The commission took into account the importance of the doctor-patient relationship and his/her family member or relatives. It was observed that advances in medical sciences and dramatic changes in health care coverage had altered the physician-patient relationship and the treatment option available to health care professionals.

The doctor-patient relationship is founded on trust but health care has become less personal or more corporate as a result doctors often ignore the rights of patients or families and relatives. Consequently, this prevents the doctor and others from respecting and carrying out the patient is dying wish. The commission further observed that although it is true that primary obligation of medical personnel was to the patient yet when the patient is dying the needs of his/her family take precedence. To ignore the rights of the bereaved family can lead to violation of value and dignity. The commission cited research literature in this regard and pointed out that human beings possess an inherent value that is independent of the state of their health or their closeness to death. If human beings have freedom of choice and action, then, for a humanistic perspective, both the patients and relative should share their views. The relationship between the doctor and dying patients includes "the moment of truth". This is not always identical to the time of explanation. Therefore, during the final crisis when it is no longer possible to stave off death, the patient has the greatest need of conversation not only with the doctor but also with her relatives. The commission, therefore, stated that such factors considerably increased the urgency on attitudes and how the doctor should have behaved at the moment. The ground rule, therefore, is that in any case the patient's relative should have been permitted to see the patient even though she was in Intermediate Respiratory Care Unit (IRCU). In conclusion, the commission
stated that patient's rights are a reflection of human rights; they are recognised throughout the world, when declaration on the promotion of patient's rights 1994 was entered into at the behest of World Health Organisation. Until recently, the health professional-patient's relationship was primarily defined by the rules of medical ethics but now the focus had shifted to legal provisions and the issue started gathering larger international attention. In this context, the commission relied on Article 21 of the Constitution of India, which guarantees the most important right— the right to life.

The term "Life" means something more than mere animal existence. The prohibition against its deprivation extends to all those limbs and faculties by which life is enjoyed. Right to life and human dignity means mixing and co-mingling with fellow human beings. Any act, which offends or impairs human dignity, would constitute deprivation protanto of this right of life unless it is done by reasonable and just procedure established by law, which stands the test of other fundamental rights. In substance, respect of human rights and values in health care becomes an important issue, which confirms the basic principal in our constitutional law, the inalienable nature of human dignity. Arrogance, nepotism, therefore, become unknown to man's status. After considering the code of medical ethics prescribed by the Maharashtra Medical Council as well as Medical Council of India, the commission recommended the practice to protect the rights of patient, his/her relatives or family members or friends as more particularly mentions in the directions. In response to the recommendation of the Commission, the Municipal Commission Brihanmumbai Municipal Corporation, Mumbai implemented the directions by means of circular to all hospitals under his control by prescribing timing visit of patient's relatives in IRCU/ICU. The commission, also recommended to the government to apply similar procedure and the government has with certain modification issued the guidelines to all hospitals under their control to follow up.
4.7.1. Occupational Health

The commission took suo motu cognisance of a news item in the *Sunday Observer* in September 1996 captioned ‘Death in the Air’ and called for a report from the government of Madhya Pradesh. The report indicated that there were 134 slate factories which were set up in Mandsaur District of Madhya Pradesh. A majority of the workers employed in these factories had been affected by the inhalation of silicon dust. The government had taken steps to provide medical facilities and ensure that all these workers were covered under the Employees State Insurance (ESI) scheme. There was a mobile van in operation to provide medical facilities to the workers. They were even provided with pensions on the declaration that the disease affected the worker, which was an occupational hazard. The district administration had advised owners of these factories to install BHEL machinery to minimise dust particles. However, many of the owners of these factories were unable to meet the cost of the sophisticated machinery. This resulted in the spread of silicosis dust and affected the workers’ health. The labour inspectors had visited the factories and prosecuted those who were not applying the minimum standards laid down. Having regard to the provisions of the Indian Constitution as well as to the International Human Rights instruments with regard to the right to life the commission gave the following directions to the state for compliance in future:

- To ensure the establishing of BHEL machinery in the factories to prevent dust pollution and to ensure that pollution free air is provided to workers.

- Periodic inspection, on a monthly basis, by the Labour Department and reports made to the State Human Rights Commission for monitoring.

- Widows and children of deceased workers to be taken care of by the factory owner by providing assistance.
• To ensure that child labour is prevented by the following methods:

  > Establishing schools at the cost of factory owners, with assistance from the State for the education of workers' children.
  > The provision of periodic payments for their education and insurance coverage at the cost of factory owners.
  > The position of mid-day meals and clothing to dependent children or children of deceased workers.

In examining this matter, the commission observed that the Right to Health and Medical Care was a fundamental right under Article 21, read with Articles 39(e), 41 and 43 of the Constitution. The Right to Life includes protection of the health and strength of workers and was a minimum requirement to enable a person to live with human dignity. The Universal Declaration of Human Rights as well as other International Instruments also spoke of this right. Continuous exposure to the corroding effect of silicon dust could result in the silent killing of those who worked in such an environment. The duty of the state, under the Directive Principles of the Constitution, was to ensure the protection of the health of workers employed in such slate factories in Mandsaur and elsewhere in the state.

4.7.2. Starvation Deaths

On December 3, 1996, the commission took cognisance of a letter from Chaturanan Mishra, then Union Minister for Agriculture regarding starvation deaths due to the drought in Bolangir district of Orissa. In a similar matter a writ petition\textsuperscript{362} was filed by the Indian Council of Legal Aid and Advice and others before the Supreme Court of India under Article 32 of the Constitution.

The petition alleged that deaths by starvation continued to occur in certain districts of Orissa. The Supreme Court on 26th July 1997 directed that since the NHRC is seized of the matter and is expected to deliver some order,

\textsuperscript{362} Writ Petition (C) No.42/97.
the petitioner can approach the commission. Realising the urgency of the matter, the commission acted quickly and initially prepared an interim measure for the two year period and also requested the Orissa state government to constitute a committee to examine all aspects of the land reform question in the KBK Districts. A Special Rapporteur has been regularly monitoring the progress of implementation of its directions. The commission observed that starvation deaths reported from some pockets of the country are invariably the consequence of mis-governance resulting from acts of omission and commission on the part of the public servant. The commission strongly supported the view that to be free from hunger is a Fundamental Right. Starvation, hence, constitutes a gross denial and violation of this right.

The commission organised a meeting with leading experts on the subject, in January, 2004 to discuss issues relating to Right to Food. It has approved the constitution of a Core Group on Right to Food that can advise on issues referred to it and also suggest appropriate programmes, which can be undertaken by the commission. By this decision, it is firmly established in the context of India that economic, social and cultural rights are treated at par with the civil and political rights before the courts and the commission. India is amongst the few countries in the world, which have accorded justiciability of economic, social and cultural rights. The issue of starvation deaths was raised in Indian Council Legal aid case by the Indian Council of Legal Aid and Advice and Others. On learning that the Commission had taken cognisance of this matter, the Supreme Court made the following observation in its Order dated July 26, 1997: In view of the fact that the National Human Rights Commission is seized of the matter and is expected to give its report after an enquiry made at the spot, it would be appropriate to await the report. Learned Counsel for the petitioner submitted that some interim directions are required to be given in the meantime. If that be so, the petitioner is permitted to approach

http://nhrc.nic.in/HRIssue.htm#Right%20to%20Food (accessed on April, 3 2007)
Writ Petition (C) No. 42/97 filed before the Supreme Court of India on 23 December 1996
the National Human Rights Commission with its suggestion. So far as this Court is concerned, the matter would be considered even for this purpose on receiving the report of the National Human Rights Commission. We also consider it appropriate to require the Union of India to appear before the National Human Rights Commission to assist the Commission in such manner as the Commission may require for the purpose of completion of the task of the Commission.

The learned Addl. Solicitor General undertakes to ensure prompt steps being taken for this purpose. After a decade long study which was completed in 2006, the NHRC report confirmed that at least 17 of the 21 starvation deaths reported in 1996-97 in Orissa were due to chronic hunger and malnutrition. All the deaths were in Kalahandi, Bolangir and Koraput or the severely deprived KBK region of Orissa. The report attributes the deaths to prolonged malnutrition and hunger compounded by extensive crop damage, poor income and inadequate relief measures. The commission has approved the constitution of a core group on Right to Food that can advise on issues referred to it and also suggest appropriate programmes, which can be undertaken by the commission.

4.7.3. Mental Health

Justice J.S. Verma, ex-chairperson, National Human Rights Commission, asked all the chief ministers of all the states and the administrators of all the union territories “to issue clear directions to the Inspector Generals of Prisons to ensure that mentally ill persons are not kept in jail under any circumstances”. Moreover, the state government must make proper arrangements for their treatment in approved mental institutions and not treat them as unwanted human beings. The commission has directed all States and union territories to certify that no mentally ill patient is kept in chains in any mental hospital/institution. A letter from the commission in this regard was sent to the chief secretaries/administrators of all states/UTs. The commission also directed all the states and UTS not to chain the mentally ill persons. The issue
came up earlier on the basis of a complaint from Prof. Dr. Nazneen of Shri Meenakshi Government College for Women, Madurai regarding the plight of mentally ill patients staying in Sultan Alayudeen Durgah, Goripalayam, Madurai (Tamil Nadu). Taking cognisance of the matter, the commission had constituted a committee to visit the Durgah and make specific recommendations in regard to the proper care and treatment of the patients. The report submitted by the committee was accepted by the commission on 3 January 2001. The commission took suo-motu cognisance of a media report, which showed gory details of inhuman treatment meted out to inmates of an unlicensed mental asylum run by a quack at Saharsa in Bihar. Reacting to the CNN-IBN news report, the commission said that the treatment methods shown in the report are primitive as the patients are tied to the tree and buckets of cold water are poured on them.

The video clipping also showed mental patients being kept in chains and being brutally beaten up. The commission said the contents of the story, if true, were an affront to human dignity and raise an issue of violation of human rights of mental patients. It directed the chief secretary; Bihar to get the matter enquired into and submits a factual report within two weeks. It further directed that if the contents of the story were found to be true, the chief secretary should intimate the commission regarding the steps being taken for release of the mental patients and the steps taken to ensure that they are provided proper medical and psychiatric treatment. The National Human Rights Commission has taken suo-motu cognisance based on media reports of a government psychiatrist at the Agra Mental Asylum, Uttar Pradesh, having charged Rs. 10,000/- to certify women clinically insane so to enable their husbands to file for divorce. A report has been sought within two weeks from the director of the hospital and the home secretary, department of home, Uttar Pradesh. As per the media report, the psychiatrist Dr. S. K. Gupta had facilitated 10 such divorces by issuing false certificates. It was also reported that Dr. Gupta has

365 NHRC Order June 20, 2006
“disappeared”. The managements of the mental hospitals at Ranchi, Agra and Gwalior came under the scrutiny of the Hon’ble Supreme Court through Writ Petitions (C) No.339/96, No.901/93, No.80/94 and No.448/94 filed by social activists. The Supreme Court in its order dated 11th November 1997 requested the National Human Rights Commission to be involved in the supervision of the functioning of these three hospitals. In pursuance of the Order, the commission has been monitoring the functioning of these hospitals through its Special Rapporteur. It had constituted an expert group on 31st December 2001 for rehabilitation of long stay patients who are languishing in these three mental hospitals even after having been cured of mental illness. Although commission has done a lot in the area of mental health, there is a blot which lingers on the commission for discriminating people on the basis of their sexual orientation. A petition was filed in the case of a patient from the All India Institute for Medical Sciences (AIIMS), who was being treated by a doctor at the AIIMS psychiatry department for the past four years to cure him of his homosexuality.

The patient himself noted that, "Men, who are confused about their sexuality, need to be given the opportunity to go back to heterosexuality. I have never been confused but was nevertheless told that I had to be ‘cured’ of my homosexuality. The doctor put me on drugs which I had been taking for four year." The patient went to the Naz Foundation India (an organization working on Men who have Sex with Men (MSM) issues), and the coordinator of the MSM Project, Shaleen Rakesh, filed a complaint with the National Human Rights Commission (NHRC), alleging psychiatric abuse involving a patient at the All India Institute of Medical Sciences (AIIMS). The treatment reportedly involved two components: counselling therapy and drugs. The NHRC, admitted the complaint (No. 3920, filed on May 29, 2001), but finally chose to reject it. In its formal dismissal of the complaint, it did not offer any written or oral opinion on the issue, and merely rejected the complaint that requested the NHRC to address the psychiatric treatment of homosexuality from a human
rights perspective. Informal conversations with the chairperson of the NHRC revealed some of the reasons why the NHRC chose not to address the issue. The chairperson believed that till Section 377 (xiv) Indian Penal Code was changed, nothing could be done. Also, most of these organisations were funded by international bodies and there was no real grass roots support. According to another NHRC source.

4.7.4. Right to Health Care

In November 2003, the commission approved a proposal received from the Jan Swasthya Abhiyan (Peoples’ Health Movement-a network of 1000 NGOs working in the health sector) to hold public hearings on Right to Health Care in five regions of the country followed by one at the national level in New Delhi. Subsequently, the western region hearing was held at Bhopal, Chennai, Lucknow, Ranchi and Guwahati. During these public hearings, selected cases or instances, wherein individuals or groups who have suffered denial of right to health care and have not received mandated health care from a public and private health facilities were presented. The commission brought victims, NGOs and concerned authorities on the same platform, which helped in the resolution of individual problems, identification of systemic problems and forging of partnerships. Over 1000 victims from marginalised sections presented their testimonies. The Commission and the concerned authorities are redressing their complaints. Systemic improvements in health care have been suggested to all concerned authorities. The active participation of NGOs and state governments has contributed considerably to the success of this programme. The National Public Hearing was held in New Delhi on December 16-17, 2004, in which civil society representatives presented the structural deficiencies noted in various regional public hearings, followed by

367 For more details on JSA and the Right to Health Care campaign go to www.phm-india.org.
368 Annual Report NHRC 2004-2005
delineation of state-wise systemic and policy issues related to denial of health care. Special presentations were made on issues such as women’s right to healthcare, children’s right to healthcare, mental health rights, right to essential drugs, health rights in the context of the private medical sector, health rights in situations of conflict and displacement, health rights in the context of the HIV/AIDS, and occupational and environmental human rights. In addition, the National Action Plan to operationalise the ‘Right to Health Care’ was proposed.

4.7.5. NHRC Recommendations for a National Action Plan to Operationalise the Right to Health Care

Enactment of a National Public Health Services Act, recognising and delineating the health rights of citizens, duties of the public health system, public health obligations of private health care providers and specifying broad legal and organizational mechanisms to operationalise these rights. This act would make mandatory many of the recommendations laid down, and would make more justiciable the denial of health care arising from systemic failures, as have been witnessed during the recent hearings. This act would also include special sections to recognise and legally protect the health rights of various sections of the population, which have special health needs: Women, children, persons affected by HIV-AIDS, persons with mental health problems, persons with disability, persons in conflict situations, persons facing displacement, workers in various hazardous occupations including unorganized and migrant workers, etc.

Delineation of model lists of essential health services at various levels: village/community, sub-centre, PHC, CHC, Sub-divisional and District hospital to be made available as a right to all citizens. Substantial increase in Central Budgetary provisions for Public health, to be increased to 2-3% of the GDP by 2009 as per the Common Minimum Programme. Convening one or more meetings of the Central Council on Health to evolve a consensus among various state governments towards operationalising the Right to Health Care across the
country. Enacting a National Clinical Establishments Regulation Act to ensure citizen's health rights Concerning the Private medical sector including right to emergency services, ensuring minimum standards, adherence to Standard treatment protocols and ceilings on prices of essential health services. Issuing a Health Services Price Control Order parallel to the Drug Price Control Order. Formulation of a Charter of Patients Rights. Setting up of a Health Services Regulatory Authority analogous to the Telecom regulatory authority, which broadly defines and sanctions what constitutes rational and ethical practice, and sets and monitors quality standards and prices of services. This is distinct and superior compared to the Indian Medical Council in that it is not representative of professional doctors alone – but includes representatives of legal health care providers, public health expertise, legal expertise, representatives of consumer, health and human rights groups and elected public representatives. Also this could independently monitor and intervene in an effective manner. Issuing National Operational Guidelines on

   Essential Drugs specifying the right of all citizens to be able to access good quality essential drugs at all levels in the public health system; promotion of generic drugs in preference to brand names; inclusion of all essential drugs under Drug Price Control Order; elimination of irrational formulations and combinations. Government of India should take steps to publish a National Drug Formulary based on the morbidity pattern of the Indian people and also on the essential drug list. Measures to integrate national health programmes with the primary health care system with decentralized planning, decision-making and implementation. Focus to be shifted from biomedical and individual based measures to social, ecological and community based measures. Such measures would include compulsory health impact assessment for all development projects; decentralized and effective surveillance and compulsory notification of prevalent diseases by all health care providers, including private practitioners. Reversal of all coercive population control measures, that are violative of basic human rights, have been shown to be less effective in
stabilizing population, and draw away significant resources and energies of the health system from public health priorities. In keeping with the spirit of the NPP 2000, steps need to be taken to eliminate and prevent all forms of coercive population control measures and the two-child norm, which targets the most vulnerable sections of society. Active participation by Union Health Ministry in a national mechanism for health services monitoring, consisting of a Central Health Services Monitoring and Consultative Committee to periodically review the implementation of health rights related to actions by the Union Government. This would also include deliberations on the underlying structural and policy issues, responsible for health rights violations. Half of the members of this committee would be drawn from national level health sector civil society platforms. NHRC would facilitate this committee. Similarly, operationalising Sectoral Health Services Monitoring Committees dealing with specific health rights issues (Women’s health, Children’s health, Mental health, Right to essential drugs, Health rights related to HIV-AIDS etc.)

The structure and functioning of the Medical Council of India should be immediately reviewed to make its functioning more democratic and transparent. Members from Civil Society Organisations concerned with health issues should also be included in the Medical Council to conform medical education to serve the needs of all citizens, especially the poor and disadvantaged. People’s access to emergency medical care is an important facet of right to health. Based on the Report of the Expert Group constituted by NHRC (Dr. P.K.Dave Committee), short-term and longterm recommendations were sent to the Centre and to all States in May 2004. In particular, the Commission recommended:

- Enunciation of a National Accident Policy;

- Establishment of a central coordinating, facilitating, monitoring and controlling committee for Emergency Medical Services (EMS) under the aegis of Ministry of Health and Family Welfare as advocated in the National Accident Policy.
• Establishment of Centralised Accident and Trauma Services in all districts of all states and union territories along with strengthening infrastructure, pre-hospital care at all government and private hospitals. Spurious drugs and sub-standard medical devices have grave implications for the enjoyment of human rights by the people. Keeping this in view all authorities are urged to take concrete steps to eliminate them. Access to Mental health care has emerged as a serious concern.

The NHRC reiterates it’s earlier recommendations based on a Study “Quality Assurance in Mental Health” which were sent to concerned authorities in the centre and in states and underlines the need to take further action in this regard.

**Recommendations to State Governments /State Health Ministries:**

Enactment of State Public Health Services Acts/ Rules, detailing and operationalising the National Public Health Services Act, recognizing and delineating the Health rights of citizens, duties of the Public health system and private health care providers and specifying broad legal and organizational mechanisms to operationalise these rights. This would include delineation of lists of essential health services at all levels: village/ community, sub-centre, PHC, CHC, Subdivisional and District hospital to be made available as a right to all citizens. This would take as a base minimum the National Lists of essential services mentioned above, but would be modified in keeping with the specific health situation in each state. These rules would also include special sections to recognise and protect the health rights of various sections of the population, which have special health needs: Women, children, persons affected by HIV/AIDS, persons with mental health problems, persons in conflict situations, persons facing displacement, workers in various hazardous occupations including unorganised and migrant workers etc.
Enacting State Clinical Establishments Rules regarding health rights concerning the private medical sector, detailing the provisions made in the National Act. Enactment of State Public Health Protection Acts that define the norms for nutritional security, drinking water quality, sanitary facilities and other key determinants of health. Such acts would complement the existing acts regarding environmental protection, working conditions etc. to ensure that citizens enjoy the full range of conditions necessary for health, along with the right to accessible, good quality health services. Substantial increase in state budgetary provisions for public health to parallel the budgetary increase at central level, this would entail at least doubling of state health budgets in real terms by 2009. Operationalising a State level health services monitoring mechanism, consisting of a State Health Services Monitoring and Consultative Committee to periodically review the implementation of health rights, and underlying policy and structural issues in the state. Half of the members of this committee would be drawn from state level health sector civil society platforms. Corresponding Monitoring and Consultative Committees with civil society involvement would be formed in all districts, and to monitor urban health services in all Class A and Class B cities. Instituting a Health Rights Redressal Mechanism at State and District levels, to enquire and take action relating to all cases of denial of health care in a time bound manner. A set of public health sector reform measures to ensure health rights through strengthening public health systems, and by making private care more accountable and equitable. The minimum aspects of a health sector reform framework that would strengthen public health systems must be laid down as an essential precondition to securing health rights. An illustrative list of such measures is as follows:

- State Governments should take steps to decentralise the health services by giving control to the respective Panchayati Raj Institutions (PRIs) from the Gram Sabha up to the district level in accordance with the XI Schedule of the 73rd and 74th Constitutional Amendment 52 of 1993.
Enough funds from the plan and non-plan allocation should be devolved to the PRIs at various levels. The local bodies should be given the responsibility to formulate and implement health projects as per the local requirements within the local overall framework of the health policy of the state. The elected representatives of the PRIs and the officers should be given adequate training in local level health planning. Integration between the health department and local bodies should be ensured in formulating and implementing the health projects at local levels.

- The adoption of a state essential drug policy that ensures full availability of essential drugs in the public health system. This would be through adoption of a graded essential drug list, transparent drug procurement and efficient drug distribution mechanisms and adequate budgetary outlay. The drug policy should also promote rational drug use in the private sector.

- The health department should prepare a State Drug Formulary based on the health status of the people of the state. The drug formulary should be supplied at free of cost to all government hospitals and at subsidized rate to the private hospitals. Regular updating of the formulary should be ensured. Treatment protocols for common disease states should be prepared and made available to the members of the medical profession.

- The adoption of an integrated community health worker programme with adequate provisioning and support, so as to reach out to the weakest rural and urban sections, providing basic primary care and strengthening community level mechanisms for preventive, promotive and curative care.
• The adoption of a detailed plan with milestones, demonstrating how essential secondary care services, including emergency care services, which constitute a basic right but are not available today, would be made universally available.

• The public notification of medically underserved areas combined with special packages administered by the local elected bodies of PRI to close these gaps in a time bound manner.

• The adoption of an integrated human resource development plan to ensure adequate availability of appropriate health human power at all levels.

• The adoption of transparent nondiscriminatory workforce management policies, especially on transfers and postings, so that medical personnel are available for working in rural areas and so that specialists are prioritised for serving in secondary care facilities according to public interest.

• The adoption of improved vigilance mechanisms to respond to and limit corruption, negligence and different forms of harassment within both the public and private health system.

• All health personnel upto the district PRI level must be administratively and financially accountable to the PRI at each level from the Gram Panchayat to the District level. Adequate financial resources must be made available at each level to ensure all basic requirements of health and medical care for all citizens. Ensuring the implementation of the Supreme Court order regarding food security, universalizing ICDS programmes and mid day school meal programmes, to address food insecurity and malnutrition, which are a major cause of ill health. People’s access to emergency medical care is an important facet of right
to health. Based on the report of the expert group constituted by the NHRC (Dr. P.K.Dave Committee), short-term and longterm recommendations were sent to the Centre and to all States in May 2004. In particular, the commission recommended:

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- Establishment of Centralized Accident and Trauma Services in all districts of all States and various Union Territories along with strengthening infrastructure, pre-hospital care at all government and private hospitals. Spurious drugs and sub-standard medical devices have grave implications for the enjoyment of human rights by the people. Keeping this in view all authorities are urged to take concrete steps to monitor and eliminate them.

Access to Mental health care has emerged as a serious concern. The NHRC reiterates its earlier recommendations based on a Study “Quality Assurance in Mental Health” which were sent to concerned authorities in the Centre and in States and underlines the need to take further action in this regard.

**Recommendations to NHRC**

NHRC would oversee the monitoring of health rights at the National level by initiating and facilitating the *Central Health Services Monitoring Committee* and at regional level by appointing *Special Rapporteurs on Health Rights* for all regions of the country. Review of all laws/statutes relating to public health from a human rights perspective and to make appropriate recommendations to the Government for bringing out suitable amendments.
**Recommendations to SHRCs**

HRCs in each state would facilitate the *State Health Rights Monitoring Committees* and oversee the functioning of the State level health rights redressal mechanisms.

**Recommendations to Jan Swasthya Abhiyan and civil society organisations**

JSA and various other civil society organizations would work for the widest possible raising of awareness on health rights – 'Health Rights Literacy' among all sections of citizens of the country. Institutions like the NHRC are the only means, which theoretically at least, hold promise of affordable access to justice for the poor and the vulnerable which constitute at least one third of India's population. Institutions like the NHRC fill an important void in a poor person's search for justice. The real significance of the commission is advocacy, to build constant pressure and act as reminder of the state obligations towards the rights. Due to the commission's insistence these economic, social and cultural rights have acquired constant public discourse in evaluating the effectiveness of the Indian state. The courts are not sufficient in themselves because of the weak support structure for legal mobilisation. The view that courts and existing national institutions are sufficient to attend to the human rights agenda is based on the assumption that support for legal mobilisation is uniform throughout. In addition, the social composition is such that the poor and the vulnerable groups form significant components in these societies. These very social segments are hardly in a position to utilise the courts as an institution to full their fundamental rights, much less their economic, social and cultural rights. In such social settings institutions like the NHRC are very much needed to keep exclusive focus on need for fulfillment of these rights and internalisation of international human rights norms.

**Organ Transplantation Act**

The Transplantation of Human Organs Act, 1994 is a recent law and the judicial decisions are few. It was enacted with a dual objective— to encourage
voluntary donations of organs and to prevent commercial exploitation and organ trade. This law legalizes transplantation of human organs in cases of live donor, brain dead donors and donors who are considered dead in a conventional sense. The Act lays down detailed procedure for organ transplantation including setting up of various committees. Transplantation is permitted only in those hospitals which are specifically registered for the purpose. In Santosh Hospitals Pvt. Ltd. vs. State Human Rights Commission the Madras High Court was considering a case of a hospital registered for kidney transplants. The complainant had undergone a kidney transplantation at this hospital under a visiting surgeon. Under the law such transplantation is permitted only in cases of relatives or out of love and affection. The donor complained to the State Human Rights Commission that though the donee had agreed to pay him Rs. 1,50,000 for his kidney he had been paid only Rs. 45,000. In the case it came out that the consent letter from the Authorisation Committee was a bogus one. The hospital tried to wash its hands off by arguing that it had only given surgical facilities to the doctor concerned and it was not otherwise concerned with this transplantation.

The Human Rights Commission recommended a CID enquiry into the whole episode and further recommended that Rs. 30,000 be paid to the donor by the government. This order was challenged in the Madras High Court. To begin with, the high court held that the State Human Rights Commission had no jurisdiction in the matter since its jurisdiction under the Act which set it up was confined to dealing with actions of public servants and neither the hospital was a public hospital nor was the doctor a public servant. Thus the court quashed the order of the State Human Rights Commission. However, the court felt that the issue was very important any way and directed the Authorities to investigate the matter and punish the culprits. In Balbir Singh vs. Authorisation Committee the Delhi High Court was concerned with a case of liver transplantation between two brothers. Due to the delays by the Authorization Committee by the time the case came up in court the patient was dead. But the
court felt it the issue was important and thus went into the rival contentions. To begin with, it held that when transplantation is between near relatives there was no need to approach the Authorisation Committee. This was needed only when an outsider was involved. The court also set up a committee and observed that:

It is appropriate that a Committee be constituted to review the provisions of the Act and the Rules in the light of observations made in the judgment. The Committee to consider examines and gives its report to the Central Government on the following:

- Based on the date available on the transplantation of organs and the working of the Authorization Committees, the Committee to examine and make its recommendations on the composition of Authorization Committees and changes, if any, required to ensure timely permissions.

- Whether the jurisdiction of the Authorization Committees should be enlarged by bringing within its ambit the process of certifying a “near relative” or the task be assigned to another designated authority.

- Review the provisions of the Act and Rules based on the experience of transplantation of organs as carried out and the difficulties arising due to the bottlenecks faced in the said process. The Committee to examine in particular provisions of Section 9 and requirement of carrying out the tests prescribed in Rule 4, certification in Form 3 to review the definition of “near relative” and make its recommendations in the light of the observations made:

  - Examine and specify the organs for transplantation of which the tests prescribed in Rule 4(1) (c) to establish the factum of being “near relative” need not be carried out when other evidence is available.

  - Examine the feasibility of establishing and setting up Organ Procurement Organizations with data bank to facilitate the dissemination of information on availability of organs for transplantation. To
encourage organ donation especially from cadavers, cases of brain-stem
deaths and other deceased persons, who had authorized removal of organs upon demise.

- Examine the feasibility of creation of a fund, the corpus to be provided partly come from the Union of India and partly by levying a fixed charge on the total bill of the hospital for transplantation and/or public donations, for providing to a donor social incentives, medical aid and facility of transplantation of organ in future, should the same be required.

- Examine and recommend ways and means to give social incentives, including but not limited, to help and aid and preferred health care, recognition and honour to a donor in the community.

- Examine the causes that lead to exploitation of poor and unaware persons in the process of organ donation and suggest methods to reduce control and ultimately eradicate such malpractices. Recommend programmes for dissemination of correct information of ethical, legal and devising procedure concerning organ donation so that a conducive atmosphere is generated and disinformation and misgivings are dispelled.

Prisoners’ Health

There are innumerable judgements of Supreme Court and high courts, showing how prisoners’ rights are violated. Some of them related to health care are mentioned here. The judgements highlight the highly unsatisfactory conditions prevailing inside prisons and the failure of the prison authorities to provide an environment which is conducive to the maintenance of prisoners’ rights, partly rooted in the belief that the prisoners do not deserve all the rights and the protections that the Constitution provides to all citizens. Besides being
morally wrong and legally invalid, this belief does not show adequate recognition of some basic facts about the prison population. In *Ramamurthy vs. State of Karnataka* the Supreme Court stated that the century-old Indian Prison Act, 1894 needs a thorough look and is required to be replaced by a new enactment which would take care of the thinking of Independent India and our constitutional mores and mandate. The Supreme Court noted that Society has an obligation towards prisoner’s health for two reasons: firstly, the prisoners do not enjoy the access to medical expertise that free citizens have.

Their incarceration places limitations on such access, choice of physician, modes of taking second opinion, and access to any specialist. Secondly, because of the conditions of their incarceration, inmates are exposed to more health hazards than free citizens. Prisoners therefore, suffer from a double handicap. The petition *Tapas Kumar Bhanja vs. State of West Bengal and Anr* was filed in 2000 by a public-spirited lawyer Tapas Kumar Bhanja. This was predominantly a complaint regarding a home called ‘Liluah Home’ for undertrial women. The grievance made in the petition was that there was overall mismanagement in this Home; that the lady prisoners were not at all safe, injustices were perpetrated; they were physically and mentally molested; they were not even provided elementary medical treatment, and that there was overall mismanagement. It was also pointed out that the number of women prisoners escaped from the Home not to be found again. This was a case where there was a gross abuse of human rights. In *CEHAT vs State of Maharashtra and Ors*, the petitioners asked for the formation of a committee comprising a dietician and doctor to review the diet scales for prisoners in the jail, as their was discrimination being practised in jails based on the origin of the inmates. The court formed a committee and asked them to recommend new or modified diet scales based on physical needs and not on origin of prisoners. The committee suggested separate diet scales for males and females alongwith
pregnant and nursing women and children. The state government agreed to implement the recommendations of the committee.

The court also directed the jail authorities to follow rule 37 of the Maharashtra prison diet 1970 strictly. According to the rule a prisoner convict or undertrial should be given court before the leaves for his hearing to the court and incase he is not been to prison it is the duty of the officer to provide whim with food if he will reach prison late after the hearing of his case. In response to a public interest litigation dealing with undertrial prisoners, R D Upadhyaya vs. State of AP, the Supreme Court carried out an in-depth examination of the issue and gave extensive directions with regard to the children of women prisoners, in a judgment delivered on April 13, 2006. The court took note of various provisions in the Constitution as well as laws enacted for the benefit of children. The court referred to a study on children of women prisoners in India, carried out by the National Institute of Criminology and Forensic Sciences. The salient features of this study are:

- Most children were living in difficult conditions and suffered deprivation relating to food, healthcare, accommodation, education and recreation.

- There were no programmes for the proper bio-psycho-social development of children in prisons. Their welfare was mostly left to the mothers. There was no trained staff to take care of the children.

- In many jails, women inmates with children were not given any special or extra food. In some jails, extra food was given in the form of a glass of milk; in others, separate food was being provided only to children over the age of five. The quality of food supplied was the same as that given to adult prisoners.
No special consideration was given to childbearing women. The same food and facilities were given to all women, irrespective of whether their children were living with them or not.

No separate or specialised medical facilities for children were available in jails.

Most mother prisoners felt that the stay in jail would have a negative impact on the physical and mental development of their children.

A crowded environment, lack of appropriate food and shelter, deprivation of affection by other members of the family, particularly the father, were perceived as stumbling blocks in the development of these children in their formative years.

Mother prisoners identified food, medical facilities, accommodation, education, recreation and the separation of children from habitual offenders as six areas that require urgent improvement.

There were no prison staff specially trained to look after children in jails. Also, no separate office with the exclusive duty of looking after the children or their mothers.

Firstly, the judgment makes clear that a child shall not be treated as an undertrial/convict while in jail with his/her mother. Such a child is entitled to food, shelter, medical care, clothing, education and recreational facilities as a matter of right. The Court directed that before sending a pregnant woman to jail, the authorities must ensure that the jail has the basic minimum facilities for delivery as well as prenatal and post-natal care for both mother and child. If a woman prisoner is found to be pregnant at the time of her admission, or afterwards, arrangements must be made to get her Examined at the district government hospital. The state of her health, pregnancy and probable date of delivery should be ascertained and proper prenatal and post-natal care provided.
in accordance with medical advice. The Supreme Court has laid down uniform guidelines applicable to all prisons in the country: Female prisoners will be allowed to keep their children with them in jail until they attain the age of six years. After the age of six, the child will be handed over to a surrogate, in accordance with the mother’s wishes, or put in an institution run by the social welfare department. Children above the age of six must be put in an institution in the same city as the prison and must be allowed to meet the mother at least once a week. In case a female prisoner dies leaving behind a child, the district magistrate must arrange for the child to be properly looked after, either by a concerned relative or a responsible person, or admitted in a social welfare department home. The non-availability of adequate medical facilities for prisoners is largely due to the lack of full time doctors as well as lack of basic infrastructure, like well-equipped ambulances, stretchers, dispensaries, hospital beds etc. Sometimes, the prisoner may need expert and urgent medical attention which is not available within the jail premises. The present day medical setup of the prisons in the districts need to be updated to such an extent that only in the complicated cases the patients are required to be referred to super specialty hospitals or the civil hospitals. It clearly appears to us that the present day setup is very poor and the prisoners deserve better treatment and better facilities.

4.8. Conclusion

With the recognition that both the Indian Constitution and the Judiciary interpretation of fundamental right to life which includes right to health began to address the importance of health to all people. In the Directive Principles of State Policy, Article 47 declares that the State shall regard the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties. Since the Directive Principles of State Policy are not enforceable by the Court, implementation of the guarantee has remained illusory. However in the series of cases mentioned above the other allied laws dealing with the substantive content of the right to life. The Court has found that the right to live with human dignity includes right to good health. In
consumer education and Research center case the Court explicitly held that the right to health was an integral factor of a meaningful right to life. Finally the Constitution framers included public health in the Directive Principles of State Policy because they were well known about it that any inclusion of right to health as F.R will have only right but it will not ensure medical facilities and consumer health education to the patients. Due to this duty and Judicial activism states are taking steps to provide health care and running of hospitals to give free health service and health care education to the public at large. A person should have health entitlements; medical aid, medical assistance health care education and right to know about his health and this have been finally taken care by Judiciary. Thus To establish right to healthcare with the above scenario certain first essential steps will be compulsory:

- Equating directive principles with fundamental rights through a constitutional amendment

- Incorporating a National Health Act which will organize the present healthcare system under a common umbrella organization as a public-private mix governed by an autonomous national health authority which will also be responsible for bringing together all resources under a single-payer mechanism

- Generating a political commitment through consensus building on right to healthcare in civil society

- Development of a strategy for pooling all financial resources deployed in the health sector

- It is necessary to eradicate public health care system which provides selective care through a multiplicity of schemes and programs, and discriminates on the basis of residence (rural-urban) in providing for entitlements for healthcare.