CHAPTER-III
Medical profession requires the skill, efficiency, accuracy of judgment and carefulness, which are the sine qua non of the profession. Though every profession has its own importance, medical profession is unique as its practice has direct link with the life of people and nothing is more precious than the life of a human being in this world. A business man having lost heavily in his business or industry due to accident or insolvency may regain his position by hard labour but precious life does not come back. Obligations of medical men therefore are very heavy. Medical offences are rooted in various kinds of liabilities like penal liability, tortious liability, contractual liability and consumer liability. This chapter makes an attempt to discuss each of these liabilities in a comprehensive manner. Penal liability under common law is explained as follows

1. Liability under Penal Law

A. Position In England

Penal liability originated from English common law. It covers crimes in general but the doctors during the course of their practice have to deal with assault, murders and manslaughter. The procedure adopted by criminal law is different to that in a civil claim. The police investigate in criminal cases and collect evidence submitting to the Crown Prosecution Service (CPS) which decides if the case is to proceed. The trial is conducted by the Magistrate’s Court or crown court, depending on the nature of the offence. An assault means

---

physical contact with another person. The legal definition of an assault is an act which intentionally causes the victim to apprehend immediate and unlawful personal violence. No touching of the victim is required for an offence to have been committed.  

In medical negligence case, patient may die during or as a result of the treatment. The death is therefore incidental, accidental or amounts to the crimes of manslaughter or murder (Collectively termed homicide). The crime of murder occurs when a person’s death in caused by someone who intends to kill or cause grievous bodily injury likely to cause death. The distinction between murder and manslaughter is the intention to kill or cause serious injury. The jury in a trial may find that the defendant intended to kill or cause grievous harm when that was his purpose or when the death (or really serious injury) was a virtually certain consequence of the action. A person may be found guilty of murder even if the victim is dying from other causes like terminal cancer if he is killed deliberately by any other means. However it is different when a patient died due to the effect of a drug given to relieve pain, as it is the act of doctors to alleviate pain and suffering. The primary purpose of administering medicine is to relieve pain and suffering will be lawful even if death is hastened (referred to the side effects). If this were not allowed, then a lot of palliative treatment would become unlawful.  

A doctor was found guilty of having attempted to give an injection of potassium to a patient who was suffering constant pain, which is not used in conventional treatment. The patient was suffering from very severe pain to the extent that she asked the doctors to give her an injection to end her life. After injecting her with conventional analgesics and sedatives, the patient was later injected with potassium chloride and died shortly thereafter. The doctor was charged with attempted murder by the prosecution as they could not prove that the potassium was the cause of death in the circumstances of the case.

3 Smith J, Smith and Hogan Criminal Law, Butterworth’s, 8th Edn, Oxford, 2001, p.58
4 Ibid.
The judge held in this case that the jury has to disregard the doctors possible motive for giving the injection and that it made no difference that the patient wanted to die or that at same point a fatal injection had been requested. Motive is not the same as intent. Another controversial liability is relating to euthanasia.

**a. Legal Liability of Doctor’s under Euthanasia**

There is an ethical debate about euthanasia but the law does not allow one to kill another person and there is no exception for the medical profession, even when a patient wants to die and agrees to being killed. Consent is not a defence to a murder charge. A patient may, for any reason, decide to commit suicide and that is a criminal offence. It is a crime to help or assist in any way another person to commit suicide. It would be a criminal offence to deliberately prescribe drugs for a patient with terminal cancer which would assert them in ending their life.

When a person kills another in circumstances that would amount to murder, the law reduces the crime to manslaughter if the defendant was either (1) provoked or (2) suffering from diminished responsibility. A person may also be found guilty of manslaughter when they carry out a dangerous and criminal act or when somebody dies due to gross negligence. The duty of care owed to the victim and which if breached, causing the death of the victim’s is negligence. The jury has to decide whether there is required standard of care. If not, then decide whether, the risk of death is due to the conduct of the defendant. An anaesthetist was found guilty of manslaughter when he failed to detach the patient from the ventilator. The endotracheal tube had become detached and after about four and a half minutes, the blood pressure monitor alarmed. The anaesthetist carried out various procedures including the administration of atropine for bradycardia, but failed to check the endotracheal connection and the patient suffered a cardiac arrest. The prosecution expert witness described the standard of care as ‘abysmal’

---

5 R v. Adomako (1994) 3 All ER 81
6 Ibid.
and stated that the conduct amounted to ‘a gross dereliction of care.’

The doctors may face criminal offences like assault, battery, hurt and grievous hurt and maintainability of the case depends upon the factual situations. Medical liability under criminal law usually focused on two bases.

One is crime of battery and the other is crime of causing grievous bodily harm.

b. Crime of Battery

Medical procedures which involve bodily touching might come within the potential scope of the crime of battery (popularly known as assault). But the absence of consent is an essential element of the offence. If legally effective consent has been given, the medical touching will not constitute the offence of battery. If legally effective consent has not been given to the doctor, the therapeutic medical touching will amount to the offence of battery. The absence of consent is the essential element. The law insisted that ‘application of force’ to which legally effective consent could not be obtained is offence of battery. The leading cases, which supported the existence of such a category, were concerned with issues as far removed from medical practice as prize-fights and flagellation for the purpose of sexual gratification. But the importance of these cases have been diminished by Attorney - Generals Reference. According to the opinion of

7 Ibid
8 Foulkner v. Tubaf (1981) 1 W.L.R. 1538, 1534
9 In the contest of the criminal Law, the term “assault” has long been used to encompass battery, or as synonym for battery, even though assault and batteries are district crimes at common law.
10 Fagan v. Commissioner of Metropolitan Police (1969) 1 Q.B.439, 444E
11 R v Coney (1882) 8 Q.B.D. 534.
13 (1981) Q.B 719 E.F.
the court of Appeal, \(^{14}\) that touching which occur in the course of medical practice do not involve ‘any hurt or injury calculated to health or comfort. In the course of medical practice there is often good reason in attempting something which is beneficial to patient’s health, even though there is a risk of harm resulting.\(^ {15}\)

All medical procedures are not intended to benefit the person on whom they are performed.\(^ {16}\) Sometime a procedure is conducted on a person with the knowledge that it will certainly be to that person’s bodily detriment, like in the case of a kidney taken from a healthy person, for transplantation into someone who is in need of it. The operation is a major one, and is not without risks.\(^ {17}\) But it is not always unreasonably dangerous, and the probable benefit to the recipient outweighs the probable detriment to the donor.\(^ {18}\) The courts may be expected to take the view that the operation did not amount to the offence of battery, even though the operation causes serious bodily harm.

There are also favourable arguments in favour of non-therapeutic medical experimentation, even if it may cause bodily harm.\(^ {19}\) Another basis of Criminal liability is the crime of causing grievous bodily harm.

\(^{14}\) Ibid.


\(^{16}\) Bravery v Bravery (1954)1 W.L.R.1169, 1180 Denning L.J.


c. Crime of Causing Grievous Bodily Harm

Causing grievous bodily injury is a crime. Consent given to a doctor absolves him of the crime. The essential element of the most serious non-fatal offence against the person is intention to cause grievous body harm. It must be determined whether the act constitutes an offence under medical procedure and, if so, whether consent will protect the doctor from liability being incurred.

It is an offence under Section 18 of the Offence Against Person Act, 1861 to cause any grievous bodily harm to any person. Grievous bodily harm is nowadays treated as a synonym for serious bodily harm. Hence a medical procedure, which does not cause really serious bodily harm, does not come within definition of the offence. If a medical procedure causes grievous bodily harm, a doctor would not be guilty of the offence, if he did it without intention to cause such harm. In Offences Against the Person Act, 1861, there is a specific requirement that the act described be committed, ‘Unlawfully’. Consent alone is not sufficient to prevent the intentional causing of grievous bodily harm from amounting to this offence.

In England criminal negligence is virtually confirmed to situation in which the patient has died, and it implies negligence of such a degree of recklessness as to amount to manslaughter or culpable homicide. The great majority of such cases are associated with drunkenness or with impaired

---

20 R v Austin (1973) 58 Cr. App.R.163.
23 Section 18 of Person Act, 1861
24 R v Clarence (1888) 22 Q.B.D. 23.
efficiency due to the use of drugs by doctors. The museum of Forensic pathology in Edinburgh contains a specimen of some 2-4 m (8 ft) of small intestine removed by a drunken obstetrician by mistake for an umbilical cord.\textsuperscript{26} Such cases are indefensible. The fact that he was drunk at the time of surgery is a negligent act that aggravates the offence.\textsuperscript{27} Thus in England Criminal negligence is virtually confined to the situations in which the patient has died, and it implies negligence to such a degree of recklessness as to amount to manslaughter or culpable homicide. Position of law in America is explained below.

\textbf{B. Basis of Criminal Liability: U.S. Position}

In United States, criminal prosecutions of physicians for negligent treatment of a patient are so rare as to be virtually non-existent.\textsuperscript{28} Obviously the most skilled physician will lose some patients unless he practices in a specialty in which death is virtually unknown. Failure to adhere to the proper standard of due care, skill and knowledge and thus becoming liable in civil damages is by no means sufficient to impose criminal liability on a physician.\textsuperscript{29}

Where a physician adopts an illegal procedure and the patient dies, he will be liable for murder. The physician who performed an illegal abortion was tried and convicted of either first degree murder or manslaughter.\textsuperscript{30} In some of these cases where the woman died during abortions, physicians are not guilty of murder, but only for the offence of abortion. In one such case, the appellate court observed that, where death results from the consequences of negligence it would see that to create criminal responsibility, the degree of negligence must be so gross as to amount to recklessness. Mere inadvertence while it might create civil liability

\begin{itemize}
\item \textsuperscript{26} Ibid.
\item \textsuperscript{27} Ibid.
\item \textsuperscript{28} Angela Roddey Holder, \textit{Medical malpractice Law}, A wiley Medical Publication, New York, 2\textsuperscript{nd} ed., 1978, p.361.
\item \textsuperscript{29} Ibid.
\item \textsuperscript{30} \textit{People v. Long}, 96 P.2d 354, cal (1939) 1939. U S R
\end{itemize}
would not suffice to create criminal liability”.\textsuperscript{31}

Abortion was legalized on medical ground in January 1973 by the Supreme Court decision. Where Women have died during abortions in the second or third trimester of pregnancy, physicians have been convicted of “Criminal negligence homicide” defined as “gross deviation from the standard of care”, and these convictions have been upheld when medical testimony was presented that no reasonable physician would have performed a late abortion by such methods in his office.\textsuperscript{32} A physician is charged with manslaughter if there is “culpable negligence, gross ignorance and lack of ordinary knowledge”. During an operation, where the doctor made large dents in the uterus of the patient pulling her intestine through them, the conviction was upheld. The court found that although a physician may use his best skill and judgment in an honest effort to care for the patient, he may be so grossly ignorant of the facts of surgery as to render him criminally responsible for the result of his ignorance.\textsuperscript{33} In another case, a patient died of burns from over exposure to x-rays administered by the doctor, and he was indicted for manslaughter.

“Not every careless act is criminal. Only when a physician exhibits a gross lack of competency or inattention or indifference to a patients safety, which may arise from gross ignorance or gross negligence does criminal liability attach. Where the patient’s death results from an error of judgment or an accident there is no criminal liability.\textsuperscript{34} Of course, assault and battery is crime, and if the patient has not consented at all and he dies as a result of the operation, the question of manslaughter may be raised.\textsuperscript{35} Before any person is convicted, the prosecution must establish and prove that the act did in fact cause the death.

\textsuperscript{31} State \textit{v.} Mc, Mahan, 65 P 2d 156, Idaho 1937. U S R 1937.
\textsuperscript{32} Munson \textit{v.} Janklow, 1973 (3) U S R.
\textsuperscript{33} Hampton \textit{v.} State S.E 2d 752 (2009)
\textsuperscript{34} State \textit{v.} Lester (1996) 111 Ohio App.3d.736
\textsuperscript{35} Washington \textit{v.} Gite, 82 L.Ed.864.1984.U.S.
As long as the treatment given to any patient is approved by a majority of the medical professionals, it is legal. Criminal liability will not attach if the patient dies unless there is a clear evidence of total and wanton disregard. If a surgeon for example, performed a non-emergency operation under influence of narcotics to the degree that he became totally reckless and the patient died, he might be subject to criminal prosecution. 36

All non-physicians practicing medicine without a license will be guilty of crime if their patients die. It is relatively uncommon for physician to be prosecuted for the death of their patients. Most prosecutions are for manslaughter, not for homicide. Since the latter require a proof of intent to kill. 37

Several chiropractors have been convicted of manslaughter for “Practicing medicine”, for example taking a diabetic off insulin and telling a paralyzed patient to fast, which he did for 35 days until he starved to death. Another chiropractor performed surgery with a “shocking degree of unskilfulness, evincing an almost incredible ignorance of surgery and anatomy and utterly wanting in skill”. It is however, absolutely necessary that the defendants action contribute at least in some material degree to the death of a sick person. 38 If there is no evidence that the patient could have been saved by proper medical treatment there is serious doubt that a manslaughter conviction against a charlatan can be sustained. 39 So the American law regarding Criminal Liability in almost the same as that in England.

36 Supra, n. 6 at p.363.
37 Ibid.
38 Supra, n. 5.
39 Ibid.
C. Criminal Liability Position in India

The presumption is that Medical profession itself is at risk and we can not enjoy the benefit of this profession, unless we take this risk. So in negligence cases criminal liability is not an accepted end of liability. In a few instances criminal liability may occur because of the proof of the intentional negligence. Criminal liability has only limited application in India. The relevant area of criminal liability under Indian law is explained as follows.

F. Strict Liability in Medical Malpractice Case

Strict liability is applicable only in rare case. The drugs, injection, glucose and blood transfusion to the patients, may sometimes cause harm to the patient. The patient may not be able to prove negligence in such cases. Neither Indian law nor English law accept the application of strict liability to the health services. If strict liability is made applicable, hospitals will stop providing the drugs and treatment due to fear of strict liability. Life – saving blood may not be available to the patients in the hospital due to hazards of contamination, making them strictly liable.40

The strict liability for supplying blood contaminated with virus serum hepatitis was questioned in case Cunningham v. Mac Neal Memorial Hospital.41 Plaintiffs alleged that she had infected serum hepatitis as a result of blood transfusion, which was contaminated. According to plaintiff, the hospital was strictly liable in tort because the blood was defective and unreasonably

41. 1979) 1 All ER. p.361
Defendant denied strict liability contending that blood is not a product and transfusion of blood is a service rather than a sale. Further there are no devices which have been developed to test and detect the serum hepatitis in the blood. The trial court dismissed the complaint for want of cause of action, holding that the rule of strict liability was not applicable. But Appeal Court held that the hospital was strictly liable. If the blood supplied is contaminated, it will be considered as if the hospital has sold defective product which is unreasonably dangerous to the consumers.

Though strict liability of hospital has been upheld in the above case the English Courts and Indian Courts have not approved the dictum. Moreover, the above case pertains to private hospital, which are charging for supply of blood, but, it does not apply to the Government run hospitals where there is no charge.

The question, whether the imposition of strict liability, should be extended to what has been considered by Person’s Commission. The report of the commission did not favour the implementation of the strict liability in general as it will be too harsh for the medical practitioners. They felt that through strict liability would put away the difficulties in proving negligence, they feared that reversing the burden of proof, will lead to an increase in defensive medicine. It would tend to imply rigid standard of professional skill beyond what present law requires, and expects.

---

42 (1979)1All ER p.361 plaintiff relied on S.402 A of the Restatement (Second) of Torts 1965 which provides (1) one who sells any product in a defective condition unreasonably dangerous to the user or consumer or his property is subject to liability for physical harm there by caused to the ultimate user or consumer or his property if (a) the seller in engaged in the business of selling such a product, and (b) it is expected to and does reach the user or consumer without substantial change in the condition in which it is sold(ii) The rule stated in Sub-Section 1 applies although: (a) the seller has excused all possible care in the preparation and sale of his product, and (b) the user or consumer has not through the product from or entered into any contractual relation with the seller.

They decided not to recommend for implementation of strict liability except for one special category of people those who volunteer for research or clinical trials. These observations of the commission deserves appreciation because if doctors are held strictly liable and incur liability without proof of negligence, they will be reluctant to give the best treatment or medicine for fear of liability. Lord Denning remarked that “we should be doing a dis-service to the community at large, if we were to impose liability on the hospitals and doctors for everything that happens to go wrong.” Therefore, the concept of strict liability will do more harm than good to the society. The patient should have redressal for whatever harm is caused to him during his stay in the hospital. He should not be allowed to suffer because of infighting and non-cooperation amongst the hospital staff. The application of strict liability should be restricted to a limited area of medical offences. In order to understand how India deals with the concept of strict liability it would be pertinent to discuss its position first under Indian Penal Code.

a. Criminal Liability under Penal Code

Indian Penal Code does not specify the crime of medical negligence, but if any act causes hurt, grievous hurt or death it may fall within the ambit of penal provision of India Penal Code and the person can be punished under section 304-A. The section states that whoever causes the death of any person by doing any act, so rashly or negligently as to endanger human life or the personal safety of other, is punishable by penal code, with imprisonment of either description for a term which may extend to two year or with fine which may extend to five hundred rupees or with both.

44 Ibid.
46 Section 337 of I.P.C
Similarly for causing hurt and grievous hurt to any person by doing an act so rash or negligent, as to endanger human life or personal safety of others, a person is liable to be punished under IPC with imprisonment of either description for term, which may extend to two year or with fine, which may extend to one thousand rupees or with both.

Under Criminal law, the injured person or representatives of deceased victims get nothing in monetary form, but the wrong doer is to be penalized or convicted. But under the Code of Criminal Procedure, 1973, the Court can make an order to pay compensation to the aggrieved, out of the penalty imposed on accused.

The most important legal provision regarding criminal liability in the Indian law is section 304 A of IPC. Medical personnel may be guilty under the provision but their criminal liability depends on rash or negligent act. The rashness or negligence must be such that the victims of medical malpractice have lost their lives; limbs or sustained bodily injuries.

These offences have insufficient protection and remedies under penal law. Under Criminal law the injured person or representatives of deceased victim of medical negligence get nothing as compensation as per Section 357 of Criminal Procedure Code, 1974, but the wrong doer is penalised or convicted. So criminal liability has limited application in medical negligence offence. It is restricted to intentional offences. Another relevant area is the position of criminal liability under Medical Council Act.

---

47 Section 338 of I.P.C.
48 Ibid.
49 Section 357 (1) (2) (3) of Cr.P.C 1973.
b. Criminal liability under Medical Council Act

The Medical Council of India constituted under the India Medical Council Act, 1956, regulates criminal liability for professional misconduct of practitioners. It is noticed that the said Act regulating the medical profession does not contain adequate provision regarding professional misconduct of medical practitioner. The inadequacy of adequate provision promotes these categories of offences.

The India Medical Council Act 1956 does not contain any provision for the protection of the interest of person who sustained negligence or deficiency in the service of medical profession. Lack of adequate provisions promote ample scope for professional misconduct. A balance between the legitimate demand from the public for proper attention and care by the doctors is the need of the hour. So it is necessary to amend the legislation in tune with the changing situation of medical negligence offence.

Another important liability relating to medical negligence is contractual liability under civil law. Contractual liability has relevant application on various aspects. Relevant areas of contractual liability have been explained below

11. Contractual Liability

Contractual liability is the main aspect of civil law. Since the inception of medical science, the human beings professing it have been abiding the principles with fidelity and sincerity. As the physician or surgeon is a skilled person, a patient has to repose confidence and faith in him. The relationship of fidelity and mutual confidence occurs at the time when doctor undertakes or assents to provide medical service. A doctor is not under obligation to render service to any one and could not be held liable for consequence of such failure to treat a person except as a government servant. Therefor the nexus between physician and patient is normally the result of implied contract between them which usually amounts

50 Clause 12 Code of Medical Ethics.
51 Ibid
to surrender of a patient before the physician to get the treatment for consideration. The obligation of physician or surgeon arises when a physician agrees to provide medical service to a patient.

In contract, liability depends upon the expressed or implied terms of contract and is based on what the medical man in question contracts to do. The duty in contract is only binding to the parties in the contract. A medical man could not examine, treat or operate a patient without the patients consent except for committing a trespass or assault. Where however the medical practitioner is privately engaged, he owes a contractual duty to attend and treat the patient and to exercise reasonable skill and care in doing so.\(^\text{52}\)

An agreement supported by consideration is contract. The terms of contract may be explicit or implied. The express terms are incorporated in the form of a single memorandum or financial exchange. The terms of implied contract can be gathered from the circumstances reflected in the custom of the profession and the conduct of the parties.\(^\text{53}\) The House of Lord’s is reluctant to allow implied contract to be used as a device to extend professional duties beyond general liability.

Liability in contract depends on the express or implied terms agreed upon by the patient and the medical man. Consent for treatment on payment of fees on the part of a patient can be treated as an implied contract with the doctor who by undertaking treatment on acceptance of fees, impliedly promises to exercise proper care and skill.\(^\text{54}\) The contractual duties are generally more onerous in nature than those imposed by tort. Tortious duties in the professional context are limited to taking reasonable care. They do not impose any continuing duty requiring advice or action to be reviewed, as may be the case with a contractual duty. Liability of retainer is more relevant in this aspect.

\(^\text{53}\) Ibid.
A. Liability of Retainer

Professionals often act as agents and contractual relationship may be established through agency. In *Everelt v. Griffiths*\(^{55}\) a doctor retained by a poor law infirmary was held to have impliedly contracted with a patient who submitted to the treatment in return for the doctor’s implied undertaking to use reasonable care. Implied contract has been explained below.

B. Implied Contract

The patient–doctor relationship is well defined by ‘Code of Medical Ethics’, issued by the Medical Council of the respective countries or on the basis of guidelines and recommendations issued by International Medical Organization and the Common Wealth Medical Association, World Medical Association and World Health Organization. The relationship of fidelity and mutual confidence take place when doctor undertakes or assents to provide medical services. Therefore the nexus between the doctor and the patient is normally on implied contract between them. Seldom, may formal agreements exist between them. Another aspect is the partnership relation between doctor and patient.

C. Partnership Relation

According to the British Medical Association, the relationship between a doctor and a patient is based on the concept of partnership and collaboration.\(^{56}\) Decisions are made through discussion between the doctor and the patient. Individual needs and preference are shared to select the best treatment option. The patient’s consent to receive treatment is the bigger in this deal. The basic principle is that the treatment is undertaken as a result of patient’s invitation.

---

\(^{55}\) [1920] 3 K B 89,163

\(^{56}\) *Ibid.*
According to Knneth\textsuperscript{57} for a good patient- doctor relationship the doctor should be a good communicator as well as technically competent. The good ‘involved partnership’ discloses to the patient about the various options available for treatment involving them in the decision making process. The relevance of legal contract is another issue related to contractual liability.

D. Legal Contract

The relationship between the doctor and the patient is also legally recognized as a contractual nature because its foundation lies in consent and contract emerges there from. The consent in a contract between a doctor and a patient may be expressed or implied. Consent by a patient may either be given by himself or any person on his behalf.

A contractual patient–doctor relationship is established when the patient makes a request for medical examination, diagnosis, opinion, advice or treatment and the doctor undertakes to provide these. The patient has every right to terminate the relationship with his doctor at any time and seek the help of another. A reciprocal right rests with the doctor who at any time, takes the help of a colleague or specialist in the best interest of his patient.\textsuperscript{58}

The patient, in doubt, despite detailed explanation by his doctor about the nature of his illness and treatment advocated, can ask for a second medical opinion. The patient is obliged to follow reasonable instructions of the doctor and participate and co-operate in the treatment and its further evaluation. Failure to do so may not allow him to hold that the doctor is responsible for any resultant damage.\textsuperscript{59} At the same time, the doctor, too must not make any promises which he cannot keep, nor should be guarantee any cure which leads to a breach of contract.

\textsuperscript{57} Aslam v. Ideal Nursing Home, (1997), CPJ Vol.81 NC
\textsuperscript{58} Ibid.
The doctor himself can terminate the relationship when he feels that his knowledge and skills are limited with respect to treatment to a patient when he feels the patient could be better treated elsewhere. Non-payment of fee does not form the ground for termination of such relationship as the contract between the doctor and the patient exists, irrespective of the payment of fees. The remedy, in such a situation lies in a suit, for recovery of the fees rather than the termination of services. Thus, if a doctor fails to fulfill his obligation, he is guilty of breach of trust and the law of contract, and the patient is entitled to claim damages for loss suffered by him due to breach of contract, under Section 75 of the Indian Contract Act, 1872, breach of contractual fiduciary duty also results in negligence on the part of the doctor under Law of Torts. Another relationship between patient and doctor is fiduciary relationship.

E. Fiduciary Relationship

This principle originated in Roman Law and fiduciary concept applies to relationship in which one person entrusts the management of his property to a second person, wherein the second person is expected to work for the benefit of the first person without making profit unfairly.

The fiduciary concept has been applied to the patient–doctor relationship as patient care resembles managing a valuable trust. It refers to doctor’s commitment to promote the patient’s vital medical interest which includes prolonging life, relieving symptoms and restoring normal functions of the body. The patients request for help and doctors offer to give it initiate the patient-doctor relationship. The doctor thereby becomes a fiduciary or trustee for patient.

---

61 Ibid.
63 Ibid.
64 *Grant v. Australian Knitting Mills Ltd.* (1936) A.C 85,103.
Contractual liability subsequently evolved as tortious liability. Tortious liability has created new dimension to medical negligence offence. The jurisprudence of medical liability is mainly focused under Tort Law. Tortious liability and its implications have been discussed extensively below.

III. Tortious Liability

Tortious liability may be the result of *centra legem artis* (Negligence). Actionable negligence occurs when injury is caused by the breach of the duty to take care. Duty to take care is the very essence of negligence. The theoretical principle of tortious liability was involved from classic decisions. In Heaven v. Pender 65 M.R. Brett laid down the rule, that the existence of duty to care must be to avoid danger. But the scope of this rule was narrowed down by Lord Esher after a decade in the case *Le Lieverev. Golud* 66 where it is said that, “A man is entitled to be as negligent as he pleases towards the whole world if he owes a duty to them.”

Subsequently, the principle “*neighbour principle*” was enunciated by House of Lord in *Donoghue v Stevenson*, 67 Lord Atkin observed that one must love his neighbour so that no injury is caused to him. Reasonable care must be taken to avoid acts or omissions, which may injure the neighbour. The person who are so closely and directly affected by your act that contemplates that you can injure them by your acts or omission, are your neighbours. The statement as to principle for determining the duty appears to be very sound and is well accepted criteria. But reasonable foreseeableness is only relevant in testing whether there exist a duty of care. Medical man owes duty to take care of patients, which arises out of assumption of responsibility by the doctor to treat the patient with due care and diligence.

---

65 (1883) 11 Q.B.D. 503
66 (1893), Q.B. 491.
67 (1932) A.C 562.
He owes a duty to the patient to use due caution in the treatment. It is
immaterial that the medical practitioner is qualified or unqualified. Once the patient
is accepted for treatment it is the duty of practitioner to diagnose properly and give
treatment according to accepted practice. It is judicially settled that mere error in
judgment or mistake in opinion does not render the practitioner liable.\textsuperscript{68} To hold the
doctor liable whenever something happens to go wrong would do a great disservice,
not only to the profession but also to the society at large. Lord Denning opinioned
that in a profession an error of judgment is not negligent.\textsuperscript{69}

\textbf{A. Accepted Practice}

Accepted practice is the most important factor of tortious liability. Physician
or surgeon acting in conformity with recognized or accepted practice is also not
guilty of negligence. It was Lord Clyde who brought the concept of accepted
medical practice in a Scottish Case, \textit{Hunter v. Hanley}\textsuperscript{70} wherein, he stated that, a
doctor adopted, a practice was one that which no professional man of ordinary skill
would have taken, had he been acting with ordinary care. Accepted practice or
custom is relevant in determining, what a man of normal prudence would have done
in like circumstance and whether or not, in the case before it, reasonable care had
been, exercised. In \textit{Clark v. Maclennon}, \textsuperscript{71}the surgeon deviated from accepted
practice of profession and the operation was unsuccessful. As a result the patient
became disabled, but the court held that departure from orthodox course of
treatment was a breach of duty.

The customary practice, employed by practitioners is not necessarily a
good medical practice as it is subject to variation according to development of
science. The usual or accepted practice of today may become absolutely useless or
worst tomorrow. It is therefore, the duty of the court to see that practitioners

\textsuperscript{68} \textit{White House v. Jordan} (1980) BMLR 14,(1881)1 All ER.

\textsuperscript{69} \textit{Ibid.}

\textsuperscript{70} (1955) S.L.T.2.Q.B.

\textsuperscript{71} (1909) 2 K.B.820.
good medical practice instead of usual practice, ‘Custom is relevant in determining followed the standard of care. It gives us information of what is feasible, it warns the possibility of far reaching consequences, if a higher standard is required, but custom can never be conclusive.” The true test for establishing negligence in diagnosing or treatment from the part of doctor is to be proved. A doctor charged with negligence may be relieved of liability if he proves that he had acted in accordance with the prevailing professional practice. M C. Nair J has laid down that a doctor is not negligent if he is acting in accordance with a practice accepted by a responsible body of medical men skilled in that particular art, merely because other doctors adopt a different practice. This has been accepted by House of Lords as applicable not only in diagnosis and treatment but also in advice and warning.

LORD DENNINGS points out that a doctor is not liable for taking one choice out of two or four favoring one school rather than another. He is only liable when he falls below the standard of a reasonably competent practitioner in his field. The allegation of negligence against the doctor could not be established due to reason of expert medical opinion as to the necessity of situation. The law in this regard is well-settled by the House of Lords that a judge’s preference to one body of distinguished professional opinion to another, also professionally distinguished, is not sufficient to establish negligence of a practitioner whose action has received the seal of approval of those whose opinion, truthfully expressed honestly held, were preferred.

The principle of law propounded by House of Lords in a subsequent decision is that, court is not bound to hold that a defendant doctor escape from liability for negligent treatment or diagnosis just because he received evidence from a number of experts who are genuinely of opinion that doctor’s treatment or diagnosis was according to sound medical practice. A judge has right to come to

---

72 Darling v. Charles Community Memorial Hospital, 3 111 2d.326. 211 N,E 2d 14 A.L.R 3d 860 (1986)
73 Supra n.68
74 Ibid.
75 Bolitho v. City and Huckney Health Authority 13 BMLR 111 affirmed by House of Lords [1972] All ER
76 Ibid.
the conclusion that views of a medical expert is unreasonable, when he is satisfied that the body of expert opinion cannot be logically supported at all, and that such opinion will not provide the bench mark by reference to which the defendant doctors conduct is to be assessed. In Joyce v. Sutton and Wandsworth Health Authority, the court of appeal observed that the defendant doctor is guilty of negligence, even if his acts or omission is in accordance with accepted clinical practice because the court is duty bound to see whether “that general practice stood up to analysis was not unreasonable in the light of the state of medical knowledge of that time.” To establish negligence it must be proved that (i) there is normal practice which is applicable to the case (ii) that the defendant has not adopted it and (iii) that the course taken by the defendants is one, which no professional man of ordinary skill would have taken, had he been lacking ordinary care.

In a famous case, the plaintiff, a voluntary patient in the defendant’s mental hospital, sustained fracture in the course of Electro Convulsive Therapy (ECT). There were two views of opinion in the profession about the mode of treatment, one of which favoured the use of relaxant drugs or manual control as a general practice, and the other, is that the use of these drugs causes mortality risks. The doctor was held not negligent in failing to administer a relaxant prior to the treatment and in failing to provide some form of manual restraint during the passing of electric current through the brain of the patient.

In Sidaway case the surgeon did not disclose the risk of damages to the spinal cord of the patient, which was less than 1%, but if materialized resulting injury could range from mild to very severe. Since the surgeon’s non-disclosure of the risk of damage to the plaintiff’s spinal cord accorded with a practice accepted as proper by a reasonable body or neuron-surgical opinion. Since the plaintiff failed

---

77 [1996] Mod.L.R.
78 Hunter v. Hanley 1955 SC 2000
to prove that the surgeon had been in duty to warn of the risk. Hence doctor was held not negligent.

But in several cases the court of appeal held that a professional person is not required to read every article appearing in the professional literature and is not negligent merely by failing to adopt immediate suggestions in such literatures. That the individual professional person will be at fault in failing to adopt the new techniques has been proved and accepted as an invariable part of the accepted practice in the profession. STREAT FIELD, J opined that a doctor was entitled to use his common sense and experience and judgment in the treatment of each case, and a slight departure from the text book would not of itself establish negligence. The defence of accepted professional practice may not absolutely protect the professional, because the court is the final authority to determine what is reasonable. The judiciary has retained the power to declare any recognized practice of the professional as negligent. Lord Browne Wilkson lays down the criteria for evaluation of accepted professional practice as follows “A doctor could be liable for negligence in respect of diagnosis and treatment. If a body of professional opinion examine his conduct has not been demonstrated to the Judge’s satisfaction that body of opinion relied on was reasonable or responsible.”

In a vast majority of cases the fact that distinguished experts in the field were of a particular opinion would demonstrate the reasonableness of that opinion. However, in a rare case, if it could be demonstrated that the professional opinion was not capable of withstanding legal analysis, the judge would be entitled to hold that the body of opinion was not reasonable or responsible.”

This is the development of law relating to accepted practice. The second factor is knowledge of science.

80 All ER [1957] 2
81 Holland v. Devitt and Moore [1996] 3 All ER
82 Supra, n.77
83 Ibid
B. Knowledge of Science

The Medical men are supposed to be aware of latest knowledge, and keep themselves up to date with the latest developments in techniques through reading of medical literature and from other sources of information available to the prudent doctor. The practice of medicine is mostly exact science. He should be aware of constant changes in the principle and practice of medicine. There are situations in which case may go beyond competence and control. Another relevant factor is skill of medical man.

C. Skill of Medical Man

Skill is inevitable in every profession. In *Uma Pinglay v. Dr. N.T. Mukerjee*\(^8^4\) it has been held that the skill of medical practitioners differ from doctor to doctor. Medical opinion may differ with regard to the course of action to be taken by doctor treating a patient as long as doctor acts in a manner which is acceptable to the medical profession. The court finds that he had attended on the patient with due care, skill and diligence and if the patient still does not survive or suffers a permanent aliment it would be difficult to hold a doctor guilty of negligence.\(^8^5\)

Similar view has been expressed in *P.N. Sudhakar Gupta v. Shri Anugrah Vittla nursing Home*.\(^8^6\) In *V.P. Shanta v. Cosmopolitan Hospital*\(^8^7\) it was held that a very high degree of probability has to be established before entering a finding of a medical negligence on the part of doctor. In *Dr. Jasmine Patel v Dr. R.J. Maneksha*,\(^8^8\) it was held that when doctor rendered his service with due care under the circumstances, he was not required to guarantee results expected by the patient and therefore could not be accused of negligence in service. Cases beyond competence and control are more relevant in this context.

\(^8^4\) 1997 (2) CPR. 160.
\(^8^5\) (1996) 2 SCC 634
\(^8^6\) (1997) 1 CPJ 226.
\(^8^7\) 2001 (1) CPR 421.
\(^8^8\) 2002 (1) CPR 392
D. Cases Beyond Competence and Control

Allegations of reasonable standard of care may arise if the doctor accepts a case beyond his competence and control. It is the duty of a general practitioner or non-specialists to consult a specialist when the situation goes beyond his control. This duty is defined by the medical profession through expert opinions. If a person is qualified practitioner, it does not mean, that he is perfect to treat every disease and every patient. He may not be liable to cure every disease. He may be held liable for recklessly undertaking every case, which he knew or should have known to be beyond his powers, or for making his patient subject to reckless experiments. Inordinate delay of treatment is another area, which constitutes possibility of causing medical liability.

E. Delay

The medical practitioner ought to provide treatment without undue delay, providing standard of care, but mere delay in treatment is not enough to indict him. The doctor who accepts the patient for treatment, has to diagnose the malady, which may take some time (for pathological tests, X-ray, ECG, etc.), before starting the treatment. Thus, delay in instituting treatment depends upon the circumstances of each individual case. Unreasonable delay in instituting treatment may amount to negligence, symptoms which should alert any reasonable doctor that the patient required some treatment.

Medical practitioner must continue treatment until the patient dismisses him. If practitioner wants to discontinue, he must express it and give sufficient time to the patient to arrange another physician. It is the duty of courts to determine, whether the doctor had requisite skill, care and diligence in rendering professional service to his patient. The test to be applied by the court is whether the doctor had requisite skill, care and diligence in rendering professional service to his patient.

---

90 P.S Mahalwar, Medical Negligence and Law Concept, Liabilities, Remedies, Deep & Deep Publication, New Delhi, 2000, p.159
The medical practitioner should advise the patient as what is to be done for example whether any pathological test, ECG test, X-ray etc need to be which any other practitioner may do in similar circumstances. Such tests may not be advised in every case, it depends upon the circumstances of the case and nature of disease. Duty of care is the fourth relevant factor of medical liability which is discussed below.

**F. Duty of Care**

The doctors owe a duty of care to their patients. Failure to show duty of care or skill in medical treatment resulting in death, injury or pain of the patient, gives rise to a cause of action in negligence. Shelat, J. delivering the Judgment in *Dr. Laxman Bal Krishnan Joshi v. Dr. Trimbak Bapu Godbole*[^91^] laid down the criteria for determination of negligence in the professional duty of a medical man defined as“A person who holds himself ready to give medical advice and treatment impliedly undertakes that he has possessed skill and knowledge for the purpose. Such a person when consulted by the patient owes him certain duties, Vz, a duty of care in the administration of that treatment, a breach of those duties gives a right of action for negligence to the patient.

The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care[^92^]. Regarding duty of care, it does not become negligence simply because something goes wrong. He is not liable for mischance or misadventure or for an error of judgment. He is not liable for taking one choice out of two or four. He is only liable when he falls below the standard of reasonably competent practitioner in his field so much so that his conduct may be deserving of censure or inexcusable[^93^]. A surgeon or anesthetist will be judged by the standard of an average practitioner of the class to which he belongs or holds himself out to belong.

[^91^]: AIR 1969 SC 128.
[^93^]: *Ibid*
The likelihood of injury or damage caused is the criterion for determination what degree of care needs to be taken in a particular case. Lord Dunedin stated that “people must guard against reasonable probabilities, but they are not bound to guard against fantastic probabilities. In Glasgow Corporation v. Muir, Lord Maxmillan also opined that the degree of care for the safety of their patient varies according to the circumstances. There is no absolute standard, but it may be said generally that the degree of care varies directly with the risk involved. To be precise, the degree of care must commensurate with the degree of risk involved in an action.

A doctor registered as homeopathic practitioner cannot prescribe allopathic medicine to the patients without being qualified in that system of medicine and without being registered under Indian Medical Council Act 1956 or the State Medical Council Act. In a particular instance a homeopathic practitioner was held guilty of negligence for prescribing allopathic medicine to the patient without being qualified in that system of medicine by the Supreme Court of India.

In a situation when a person who holds himself to give medical advice and treatment impliedly undertakes that he is possessing of skill and knowledge for that purpose. A duty of care includes what treatment is to be given or how it is to be administered. A breach of duty or duties gives a right of action to the patient to sue for the negligence. The practitioner must have a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor the very low degree is wanted. Such ordinary care and competence judged in the light of the particular circumstances of each case is what the law requires.

---

94 [1943] AC 448 ; [1943] All ER 44

"When the law, under which a person was registered as a medical practioner, required him to practice in homeopathy only, he was under a statutory duty not to enter the field of any other system of medicine and when he trespassed into a prohibited field,
It is a widely recognized proposition of law that a person will be guilty of negligence, if he undertakes a task, which he knows or ought to know that he is not qualified to give treatment or advice. He will be guilty of negligence, if damage results from such undertaking’s as held in Gracy Kutty v. Dr. Annamma. It was held that the duty of a medical practitioner is based on the fact that he is handling a human being. If the doctor is not qualified in that system his conduct amount to actionable negligence. A physician who diagnoses and treats a person for a disease or a surgeon who performs an operation on a patient to remove or rectify a defect is presumably takes an undertaking that he possesses the required skill and knowledge for the purpose.

In Murphy v. Brentwod Dc the House of Lords formulated a rule limiting the scope for recovery of loss from the doctor in certain situations. Another kind of damage of tort of negligence is ‘nervous shock’- now days usually referred to as ‘psychiatric injury’ or ‘mental distress’. House of Lord’s decision in Alcock v. Chief constable of south Yorkshire indicates that liability will tend to be limited to a small class consisting for the most part of immediate relative of the victim present at the scene of accident or its immediate aftermath.

The concept of duty is also used to categorise claims for compensation with reference to class of claimants and defendants. The common law at one stage failed to recognize the unborn child or embryo in the womb as a claimant, and thus statutory intervention was required to get the rule revised. The court have since changed their minds on the question of the availability of an action by a child born alive for injuries sustained in the womb, but for the most purpose the English Common law has been now ousted by the Congenital Disabilities (Civil liability) Act 1976.

96 [1991] 1 CPR 251
97 [1992] AC 398
98 [1991] 1 AC .294
The Doctor is duty bound in two respects. He owes a ‘primary’ duty of care in deciding whether he should undertake the case. If he undertakes the case, the next duty is cast on him. The duty of care in the administration of the treatment wherein he should use diligence, care, knowledge and caution. His failure to perform either of the above two duties, if proved, will offer a valid ground to fasten negligence on him.

According to Lord Nathan the medical man’s duty of care is based upon the fact that the medical man undertakes the care and treatment. In other words, a doctor who holds himself out as possessing special skill and assumes responsibility for an individual there by undertakes duty of care. The duty exists between patient and General practitioner, hospital, doctors, institution or health care professionals. They are guilty of negligence, if damage results from such undertaking. So there is no doubt that a medical man has a duty to care. The next important question would be whether this duty can be delegated.

a. Delegation of Duty

Delegation of duty is a part of the duty of care. A medical practitioner undertaking the treatment of patient is personally liable for the diagnosis and treatment. A surgeon retained to perform an operation will be liable if he delegates his duty to colleague who fails to use reasonable care. Medical practitioner may delegate part of his work to another doctor, but he remains responsible for any lack of care in the performance of the delegated work. The contractual duties of care and skill are non-delegable in the sense that performance of some works of the retainer may be delegated, but the responsibility for it cannot. The general tortious duty which cannot be assimilated to the contractual one, is that a person is not liable when another to whom he had delegated a duty performs it negligently, unless that person acted with reasonable care in selecting the person to whom performance was delegated.

99 Lord Nathan, Medical Negligence, Sweet & Maxwell Publication, London. 1957 p.8
100 Supra, n. 89.
101 Morris v. Winsbury White [1957] 4 All ER
The English law does not recognize the team standard. Accordingly the responsibility of a nurse in the course of an operation is different from that of a surgeon.\textsuperscript{103} Mustill L J, rejected notion of a team standard of care “where by each of the persons who formed the staff of the unit held themselves as capable of undertaking the specialized procedures which that unit set out to perform” on the ground that it would expose that a student nurse was negligent for failure to possess the skill and experience of an experienced staff.

Duty towards patient exists not only for the radio-graphers,\textsuperscript{104} anaesthetists,\textsuperscript{105} Pathologists\textsuperscript{106}, dentists, and nurses,\textsuperscript{107} also by the Hospital staff.\textsuperscript{108} The hospital authority is not only responsible for the negligence of the physicians, surgeon, and nurses in the course of their professional duties but the hospital authority is legally responsible to the patient for due performance of ministerial or administrative duties of its servants.\textsuperscript{109} The distinction drawn by Kennedy, LJ between professional duties and ministerial or administrative duties has been disapproved by the court of Appeal in \textit{Cassidy v. Ministry of Health}.\textsuperscript{110} The court laid down that the hospitals are liable for negligence of the members of the hospital staff including nurses and doctors. The nursing home and the private hospital are not responsible for the negligence of the physicians and surgeon who are not appointed by the nursing home and the private hospital.\textsuperscript{111}

\begin{thebibliography}{99}
\bibitem{103} bid.
\bibitem{104} Jones v. Manchester Corporation [1952] 2 Q.B.520
\bibitem{105} Clarter v. Mullan [1908] 1 All ER. p.247.
\bibitem{106} Edward v. Mullan [1908] 1 K.B.1002.
\bibitem{107} Hillye v.St. Bar Thomews Hospital [1909] 2 K.B.1002.
\bibitem{108} Ibid.
\bibitem{109} [1942] 2 K.B .293; [1942] 2 All ER.
\bibitem{110} [1951] 2 KB 343, [1951] 1 All ER 574.
\end{thebibliography}
LORD DENNING\(^{112}\) has summarized the proposition by expressing the view that the hospital is liable if it provides the specialist, but not if the patient obtains him. The hospital is liable when an unqualified surgeon negligently injects a patient with cocaine in mistake for procaine, \(^{113}\) when the medical staff was negligent in the post-operational treatment of a patient, \(^{114}\) on when an anesthetic was negligently administered by a physician \(^{115}\), and when a radiographer was negligent in providing adequate screening material during the use of X-rays. \(^{116}\) The hospital authority is held liable for its failure to warn the patient of the danger of infection of puerperal fever occurring in the hospital with the knowledge of the medical superintendent. \(^{117}\) In a Canadian case the hospital was held liable for negligence when in the absence of a nurse, a seven-year-old boy fell out of the window and suffered injuries. Even the hospital could not escape its liability for negligence of part time medical man attached to the hospital.

Position in India is more or less similar. In *Hargot Alhuwalia’s case*\(^{118}\) attending doctor allowed the unqualified nurse to give lariago injection intravenously to the patient, while the consultant doctor advised that the lariago injection must be given by the doctor. The Supreme Court of India held that the hospital is liable to any compensation for the negligence of its staff. The principle enunciated is that the delegation of duty to another may amount to negligence in certain circumstances. A consultant could be negligent where he delegates the responsibility to his junior with the knowledge that the junior was incapable of performing his duties properly. An instance of leaving critically ill patient under the care of unqualified compounder particularly when the situation demands constant monitoring of the patient, amount to deficiency-in-service. Similarly, negligence is

\(^{112}\) *Supra*, n. 45

\(^{113}\) *Supra*, n.111

\(^{114}\) *Supra n.*110

\(^{115}\) *Supra*, n.105

\(^{116}\) *Supra*, n. 104

\(^{117}\) Lindsey C.C Marshall [1937] AC 97, [1936] 2 All ER

attributed to the doctor for leaving the patient under the care of a compounder who
casted death of the patient by administering “Nivaquine” injection. The ESI hospital was held liable for not giving proper timely medical treatment to the patient and for refusal to admit the patient in the hospital for treatment of acute pain in abdomen by the attending doctor of the hospital. Similarly hospital was directed to pay compensation to the patient for suffering caused by leaving sponge in the abdomen of the patient during operation.

The Supreme Court of India directed the State of Maharashtra to pay compensation to the legal representatives of a deceased patient who died after sterilization operation in a Government Hospital due to the negligence of the Government doctor who left a mop (towel) inside the peritoneal cavity of the patient during the operation. The High court of the Rajasthan also directed the State Government to pay compensation to the husband of the deceased patient whose death was caused by insertion of pneumoperitoneal needle during laparoscopic tubectomy in a Government hospital.

There are the various aspect of law relating to delegation of duty and, malpractice related to those cases. The next relevant area is breach of duty and its related legal complication.

b. Breach of Duty

The issue of breach of duty is covered with whether the defendant was careless, in the sense of failing to conform to the standard of care applicable to him. The level at which the standard is set is a question of law. In Hazell v British transport commission Person j said that:

119. Aleyamma Vurghese v Dewan Bahadur 1996 CPJ 911, 1997( 1) CPR ( Ker.)
120. A.M, Mathew v Director, Karuna Hospital, 1998 (1) CPR 39( Ker),1998 CPJ 476 Ker
122. Rajammal v. State of Rajasthan ,1996 ACJ 1166
“The basic rule is that negligence consists of doing something which a reasonable man would not have done in that situation or omitting to do something which a reasonable man would have done in that situation, and I approach with skepticism any suggestion that there is any other rule of law, properly so called, in any of these cases.”

A more far-reaching effort to inject some substance into the basic negligence standard was made by Learned Hand J. in a series of American Cases. According to the ‘Hand Formula’ the standard of care may be expressed in terms of three variables: the probability that harm will result to the claimant from the defendants act or omission; the gravity of the loss or harm, the cost and burden of preventing it. A breach occurs when the cost to the defendant of taking the necessary precaution is out weighed by the magnitude of the risk and the gravity of the possible harm to the claimant. In Conway v. O’ Brie Learned Hand J 124 described his approach in these terms.

The degree of care demanded of a person on occasion is the result of three factors: The likelihood that his conduct will injure others, taken with the seriousness of the injury if it happens, and balanced against the interest which he must sacrifice to avoid the risk. All these are practically not susceptible of any quantitative estimate, and the second two are generally not so, even theoretically. For this reason a solution always involves some preference, or choice between in commensurable and it is thought most likely to accord with commonly accepted standard, real or fancied. In Nettleship v. Western Megews 125 L.J remarked that ‘tortious liability’ has in many cases ceased to be based on moral blameworthiness’. These are the developments of law with regards to breach of duty. Another aspect is the meaning of reasonable care under medical liability.

124 [1965] WLR 169,171
125 [1978] WLR 173
c. Reasonable Care

Every person has a duty to take reasonable care to avoid foreseeable harm to his neighbor. The professional has no duty to guard against the risk, which is beyond the ambit of the professional in contemplation and as such truly unforeseeable. The question whether the risk involved in medical treatment is foreseeable, is to be judged according to the knowledge possessed by the profession at the time of accident, and not by wisdom of hindsight. The subsequent development of medical knowledge cannot be taken into consideration to hold the professional negligent. An anesthetist acquitted of the charge of negligence for administering an anesthetic kept in a manner considered safe in 1947, though the subsequent development of medical knowledge proved the manner of keeping the anesthetic as dangerous. To paraphrase Lord Denning, “We must not look at a 1947 accident with 1954 spectacles.”

The standard of reasonable care is a flexible criterion capable of setting the boundaries of legal liability of the professionals depending on duties founded on torts or contract. The standard can be assessed in an objective manner according to the nature of the task undertaken by the professional, irrespective of his qualification or job title. In experience the test of reasonable care is applicable not only to the member of medical profession, but also to the hospital authority. The hospital authority can be held liable, if it fails to provide properly qualified and competent medical staff for treatment unit. To diagnose and to prescribe treatment over telephone in the circumstances in which the doctor could have called on the patient personally, may suggest want of reasonable care on the part of the doctor. Failure of the nursing staff to ensure that adequate supervision was

---

126 Donoghue v. Stevenson [1932] AC 562; 147 LT 281; [1932] All ER.
129 Burnett v. Chelsea and Kensington Hospital Management Committee [1968] 1 All ER 1068.
maintained in a ward of psychiatric patients may prove negligence of the hospital authority.\textsuperscript{130} Want of reasonable care may be inferred from the facts where the doctor has omitted to ensure that adequate information as to the treatment was given or not, and also failure to review and monitor medical service provided. As management of data bases improves, and information, quality of staff physician becomes accessible, the hospital has obligation to use that information responsible to ensure patient care. This is the position of law relating to reasonable care. The next factor is standard of care. The standard of care is a core area of tortious liability.

d. Standard of Care

Standard of care is the main component of tort law. The question of duty of doctor towards his patient and standard of care was discussed by Supreme Court of India quoting from Halsbury’s Laws of England, as Lordship observed. “A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties ie, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or duty of care in the administration of that treatment. A breach of any of those duties give right of action for negligence to the patient.\textsuperscript{131}” Their Lordship also held said, the doctor, no doubt, has discretion in choosing the treatment which he proposes to give to the patient and such discretion is relatively ample in cases of emergency.

Thus our Supreme Court has also affirmed the English law on the subject and laid down two propositions, firstly breach of duty of care is the basis of liability for negligence, and secondly, it lays down the standard of care i.e., 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

\textsuperscript{130} Ibid
\textsuperscript{131} Supra, n.104
degree of care). Chagla A.g C.J and Bhagwat J, observed, “the law on the subject is rarely not in dispute. The plaintiff has to establish first that there had been a want of competent care and skill on the part of defendant to such an extent as to lead to bad result. The plaintiff has also to establish the necessary connection between the negligence of defendant and the ultimate death of plaintiff son.\textsuperscript{132} Chagla C.J. and Bhagwati j observed that, action for negligence in India is determined accordingly to the principle of English common law and these principles have been set out in an action for negligence against medical man by Harle C.J. in \textit{Rich v. Pierpoint}.\textsuperscript{133} Justice Tendolker held that the degree of competence, care and skill by which the defendant is to be judged must be such care and skill as may reasonably be expected from an average man in his profession and not from any person specifically gifted or qualified. The defendant was a general practitioner, the judge said, and was to be judged by the average standard of a general practitioner and not even of a consultant, much less of a surgeon who cures diseases by operation and not by medical treatment.

Later, the duty and standard of care required by a doctor towards his patient was also discussed in \textit{Philips India Ltd v. Kuju Punnu and another}\textsuperscript{134} by the same High court which considered and approved the principles laid down in \textit{R. v. Bateman}\textsuperscript{135} that there is no question of warranty or undertaking in case of skilled profession. The defendant changed the general and approved practice. It is not required in discharge of his duty of care that he should use the highest degree of skill, since they may be acquired. Even deviation from normal professional practice is not necessarily evidence of negligence.\textsuperscript{136} According to Lord Nathan, the medical man is not an insurer, he does not warrant that his treatment will succeed or that he will perform a cure. Naturally, he will not be liable if, by reason of some peculiarity

\textsuperscript{132} \textit{Amelia Founder v. Dr. Clement Pereria} AIR 1952, Bom.p.254

\textsuperscript{133} (1862) 176 E.R 16

\textsuperscript{134} AIR 1975 Bombay 306.

\textsuperscript{135} \textit{Supra}, n.89.

\textsuperscript{136} \textit{Dr. Laxman Bal Krishna Joshi v. Trimbak Bapu Godpole} AIR 1969 SC 128
in the form or constitution of a patient which was not reasonably to be anticipated, a
treatment which in ordinary circumstances would be sound, has unforeseen
result.\textsuperscript{137}

The standard of care, which the law requires is not insurances against
accidental slips. It is such a degree of care as a normally skilful member of the
profession may reasonably be expected to exercise in the actual circumstances of
the case in question. It is not every slip or mistake, which amounts to negligence.
Thus in order to decide, whether negligence is established in any particular case, the
act or omission or course of conduct complained of must be judged not by ideal
standard, not in the abstract, but against the background of the circumstance, in
which the treatment in question was given. This is not to say that the standard of
skill and care required varies with the circumstance of each case. It is the degree of
care, which varies, not the standard. It may be said that the degree of care, which a
medical practitioner must exercise, corresponds to the degree of negligence for
which he is liable. The national commission in \textit{Bhajanlal Gupta v. Mool Chand
Kharati Ram Hospital},\textsuperscript{138} discussed the standard of care and duty that a medical
practitioner owes to his patient. It was observed that a medical practitioner has
various duties towards the patient and he must act with a reasonable degree of skill
and knowledge and must exercise a reasonable degree of care. This is the least,
which a patient expects from a doctor. The skill of medical practitioner differs from
doctor to doctor. Courts would be slow indeed in attributing negligence on the part
of the doctor if he has performed his duties to the best of his ability and with due
care and caution\textsuperscript{139} Medical opinion may differ with regard to the course of action to
be taken by a doctor treating a patient, but as long as the doctor acts in a manner
which is acceptable to the medical profession and the court finds that he has
attended the patient with due care, skill and diligence and if the patient still does not
survive or suffer a permanent ailment, it would be difficult to hold the doctor guilty
of negligence. But in cases where the doctors acted carelessly and in a manner,
which is not expected of medical practitioner, then in such a case an action in tort
would be maintainable. The standard of care expected of a medical man is neither

\textsuperscript{137} \textit{Ibid.}

\textsuperscript{138} 2000 (1) CPR 70

\textsuperscript{139} \textit{Ibid}
too high nor too low. All that the law expects from him is to exercise reasonable care expected of a skilled medical practitioner. Further, the circumstances under which a doctor is functioning and the tension borne by him while dealing with several cases also cannot be overlooked.

Preservation and production of medical records, history chart, treatment chart and investigations etc can obviate many problems and prevent litigation. Even during the trial of a pending case, production or non-production thereof can raise presumptions in the judicial mind. In *Dr. Shyam Kumar v. Rameshbhai Harmanbhai Kanchhier*,\(^{140}\) it has been observed that there are various acts in U.K. to deal with the issue of medical records like Data Protection Act, 1984, Medical Record Act, 1999 etc…, there is no such specified Act in India. But the Medical Council of India has suggested that the doctors preserve the records so as to enable him to answer his patient’s question as to the treatment proposed. In other words to obtain a valid consent of a patient a doctor is duty bound to inform the patient about risk involved in proposed treatment and also about alternative treatment if any. So it is high time to formulate commonly accepted standard guidelines for the degree of care. The Standard of care in medical negligence is the standard of a reasonable professional, namely ‘reasonable doctor’ and it is the same in both diagnosis and treatment.\(^{141}\) The standard will be determined at the time of treatment not at the later time of the trial.\(^{142}\) In *Bolam v. Friern HMA*\(^{143}\) the Judge said that; the appropriate test is the standard of ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is sufficient if he exercised the ordinary skill of an ordinary man exercising in a particular art. The standard that a specialist has to attain is that of the ordinary competent practitioner of his capacity. In the word of Lord Scarman, a doctor who professes to exercise a special skill must exercise ‘the Ordinary skill of his specialty’. Professional standard is another area which requires explanation.

\(^{140}\) 2002 (1) CPR 320

\(^{141}\) *Mahon v. Osborn* [1939] 2 KB 14

\(^{142}\) *Ibid.*

\(^{143}\) *Bolam v. Friern Hospital* [1937], WLR 582
G. Professional Standards

Professional men and women are governed by the standard of care of a normal person of their occupation or specialisation. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. An extension of this principle is applied in Bolam test, by virtue of which a professional person is exonerated if he has acted according with a practice of respectable body of opinion in his field. Thus, ‘he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.’

An important aspect of the Bolam test is that the Court would not expect the defendant to have anticipated future developments in knowledge or practice. He will be judged by the state of knowledge of the normal professional at the time of the alleged tort. The court stated that in the context of medical negligence, a ‘mere error of judgment is unlikely to amount to carelessness, despite the potentially grave consequence of such an error.

The Bolam test was considered and broadly confirmed by the House of Lords in Sidaway v. Bethlem Royal Hospital. This concerned the question of ‘informed consent’ and the extent of the doctor’s obligation to inform the patient of significant risk attached to a particular course of treatment. In Lord Bridge’s views (with whom Lord Keith of Kinkel disagreed) the appellant’s expert witness agreement that the non disclosure complained of, accorded with a practice accepted as proper by a reasonable body of neuro-surgical opinion. It afforded the respondent with a complete defence to the appellant’s claim.

However, Lord Bridge did not accept that the Bolam test would apply in every instance. Lord Bridge quoted here as even in a case where no expert witness is relevant in medical field condemns that non-disclosure as being in conflict with accepted and responsible medical practice. He was of opinion that the judge might

144 Ibid.
in certain circumstances come to the conclusion that the disclosure of a particular risk was so obviously necessary to an informed choice on the patient that no reasonably prudent medical man could fail to make it.

In *Bolith v. City Hackney Health Authority*\(^ {146}\) the House of Lords confirmed the general position that while the *Bolam* test was still good law, there remained some scope for the judge to depart from the standard set by general professional practice when setting the legal standard. According to Lord Brown-Wilkinson the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he gets evidence from a number of medical experts who are genuinely of opinion that the defendant’s treatment or diagnosis, accorded with sound practice. The court has to be satisfied that the exponent of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular case involving, as they so often do, the weighing of risk against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter. Standard of care of medical staff is relevant here.

**a. Standard of Care of Medical Staff**

Medical practitioners are assisted by qualified nursing staff and technical experts for clinical procedure. However, expert, skilled or careful a doctor may be, a little carelessness on the part of the assisting staff may cause injury to the patient or may show bad results. Paramedical staff therefore ought to be very careful. There is plenty of evidence to support that the negligence of subordinate staff led to serious complications resulting sometimes in the death of the patient. Drugs other than prescribed by doctor are administered, injections are given without proper examination of blood, urine, sputum etc……. Samples set for pathological tests are

\(^ {146}\) *Supra*, n. 75
exchanged causing wrong diagnosis and sometime even instrument and bandages are not properly sterilized before use. A number of patients are subjected to wrong treatment and many of them die due to negligence on the part of Para medical staff.

Practice of medicine involves many functions to be discharged by physician, some of which have to be delegated to the assisting staff and such delegation of duties imposes obligation to exercise that standard of care, which the medical practitioner is expected to exercise in discharge of those functions. Failure to attain that standard may amount to actionable negligence. Since these people are performing that function of physician and in many fields they are more skilled and expert than their superior practitioner, it will be quite legitimate to expect from them standard of care of a medical practitioner especially in those fields, where they are discharging the doctor’s function. In an operation theatre, the standard of care to be taken by the assisting staff and nurses whose job is to coat the swabs, while stitching incisions, is less than the care taken by surgeon in performing operations.

There can be no hard and fast rule to measure the standard of care of paramedical staff because it varies according to the circumstances of the case, e.g., in giving injection, in administrating glucose or blood, in measuring blood pressure or whether they are in casualty ward or in operation theatre. In only those cases where the nurse or any member of the assisting staff fails to attain the level of required nursing and care, which any ordinarily prudent and skilled member of the staff of similar status and category would have attained in the similar circumstances, the tortious liability will arise. It is high time to frame criteria regarding the standard of care in this area. Another area that requires extensive discussions is “proving of standard of care”.

b. Proving the Standard of Care

Proof of standard of care is the most relevant area. Proving carelessness can be a considerable task in a medical negligence action. It almost always involves adducing expert evidence. Occasionally the use of the maxim res ipsa loquitur may raise an inference of carelessness against the doctor. In practice, however, this tends
to be so in the most obvious cases, for example, where forceps are left inside the claimant’s body. In *Sidaway* case, Lord Scarman said that the law imposes the duty of care but the standard of care is the matter of medical judgment.

Later in *Bolitho v. City and Hackney HA* the Law Lords accepted the trial judges finding that the doctor would not have incubated the patient had she attended him. However, that was not the only relevant question as causation could also be established by proving that she ought to have incubated, that is, her failure would, itself, have been negligent. The expert evidence that was given supported two practices: one that would have incubated the patient and another that would not have. House of Lords held that the court could not inquire whether the body of the professional opinion was ‘reasonable’ or ‘responsible’.

Lord Browne-Wilkinson acknowledged that it would be a ‘rare’ or ‘exceptional’ case where judicial intervention will be justified. It will seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. Clinical judgment will, in all probability, remain untouched by the court’s reviewing eye, as *Bolitho* and a subsequent decision show; but they will be subject to it and that is a very important reaffirmation of the court’s role. The skill and knowledge of the medical practitioner is relevant in this context. The next is the factor relating to skill and knowledge.

### H. Skill, knowledge

A person holding himself out to be competent to do some special kind of job, is liable to pay compensation for negligence which has been caused by the failure to exercise due care and skill, either by proving that he did not possess the requisite skill or by showing that although he possessed it, he did not exercise it in

---

147 *Mahon v. Osborn*, [1939] 2 KB 14
148 *Supra*, n. 75
the particular case.\textsuperscript{150} Shelat, J. delivering the judgment of the Supreme Court of India has laid down the standard of skill and knowledge of medical practitioner in the following way “A person who holds himself ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give, or duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to 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 a very low degree of care and competence judged in the light of the particular circumstances of each case is what he requires.”

The standard of care and skill to satisfy the duty in torts is that of the ordinary competent medical practitioner exercising the ordinary degree of professional skill. \textsuperscript{151} It is true that a doctor does not undertake that he will positively care for a patient, nor does he undertake to use highest possible degree of skill, as there may be persons more learned and skilled than himself but he definitely undertakes to use fair, reasonable and competent degree of skill.

The standard of skill and competence expected from a medical man is illustrated by M C Nair, J as follows.

“A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in the particular art. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of, opinion that takes a contrary view.” It is held by the privy council\textsuperscript{152} that the standard of care and skill, to be attained, is that of the ordinary competent medical practitioner who is exercising the ordinary degree of professional skill.

\begin{flushleft}
\textsuperscript{151} Philips India Ltd v. Kunju Pennu AIR 1975 Bom.306  \\
\textsuperscript{152} Chinkew v Government of Malaysia [1967] WLR 813; 111 Sol jo 333 PC;1967 ACJ 379
\end{flushleft}
Later in *Poonam Verma’s case*\(^{153}\) a doctor registered as homeopathic practitioner treated the patient for eight days with strong antibiotics without making any diagnosis through pathological test and also prescribed intra-muscular injection of sodium compound to relieve the fever. Patient died in a hospital without any positive diagnosis. The Supreme Court of India held the homeopathic doctor guilty of negligence in giving allopathic medicine. The State Commission, Karnataka,\(^{154}\) held the homoeopathic doctor guilty of negligence for prescribing allopathic drugs to the patient who lost eyesight due to adverse reaction of the drugs. Similarly, the State commission, Punjab\(^{155}\) held one unqualified doctor negligent for giving treatment in allopathic system of medicine to the patient whose left arm was amputated due to unskilled treatment of fracture of the bone. The doctor registered under Mysore Ayurvedic and Unani Practitioner Registration and Medical Practitioner Miscellaneous Provision Act, 1961 was held liable in negligence by the State Commission, Kerala\(^{156}\) for conducting medical termination of pregnancy and for practicing modern scientific medicine beyond the State of Karnataka. Those are the aspects of development of law relating to skill, knowledge and competence of medical practitioner. Another relevant area is legal impact and application of different opinion and school related to the science of medical knowledge.

### a. Different Opinion and School Related to the Science of Medical Knowledge

There can be two schools of thought, suggesting two different opinions. A practitioner who accepted and followed one of them cannot be held negligent merely because this belonged to another school of thought. If the courts start interfering with the conduct of medical men it will hamper the development of service, for no practitioner would like to adopt new techniques or experiment with new treatments. He should be permitted to practice his profession with liberty but

---

\(^{153}\) AIR 1996 SC 2111

\(^{154}\) *Dr. A.M. Mulla v. Mushkesab Jsmail Nonawards* 1992 (2) CPR 353

\(^{155}\) *Dr. Ali Mohammed Shahi v. Harbans Lal Alias Bansi through natural guardian Kuldipsingh*, 2000 CP (SCDRC)

\(^{156}\) *Supra*, n. 153
should not be allowed to escape liability when he falls below the standard of reasonably competent practitioner.

b. Advice, Information and Warning

A doctor’s professional functions may be divided into three phases: diagnosis, advice and treatment. The objective, sometimes conflicting, sometimes unattainable, of the doctor’s services, are the prolongation of life, the restoration of the patient to full physical and mental health and the alleviation of pain. Where there are dangers to the treatment that may produce results, direct or indirect, which are harmful to the patient, those dangers must be weighed by the doctor before he recommends the treatment. The patient is entitled to consider and reject the recommended treatment and for that purpose to understand the doctor’s advice and the possibility of harm resulting from the treatment.\textsuperscript{157} This entitlement is the foundation of the doctrine of “informed consent” enunciated by the Court of United States of America. The doctrine of “informed consent to medical treatment” is based on the landmark case of \textit{Canterbury v. Spence}\textsuperscript{158} wherein the United State Court of Appeal, District of Columbia circuit, laid down the following propositions. Every human being of adult years and of sound mind has the right to determine what shall be done with his own body.

(i). The consent is the informed exercise of a choice which entails an opportunity to evaluate knowledgeable option available and the risks attached to each.

(ii) The doctor must disclose all material risks to which a reasonable man would attach significance in deciding whether or not to forgo the proposed therapy.

\textsuperscript{157} \textit{Ibid.}

\textsuperscript{158} 464 2d 772 (1972)
(iii) The ‘therapeutic privilege’ enables the doctor to withhold from his patient information as to risk if it can be shown that disclosure would have posed a serious threat of psychological detriment to the patient. The above propositions set a standard and formulate a test of doctor’s duty, the effect of which is that the court determines the scope of the duty and decides whether the doctor has acted in breach of his duty. The doctor is liable if he omits to warn where the risk is such that in the court’s view a prudent person in the patient’s situation would have regarded it as significant.

Again in LASKIN.C.J, 159 the Canadian Supreme Court expressed broad approval of the doctrine enunciated in Canterbury v. Spence. The duty of a doctor to warn was considered in Bolam v. Friern Hospital Management Committee. 160 Where the plaintiff claimed damages alleging negligence (i) in failing to administer a relaxant drug prior to the treatment. ii) in failing to provide some form of manual restraint during the passing of electric current through his brain, and (iii) in failing to warn him of the risk involved in the treatment.

M C Nair. J 161 laid down (i) that a doctor was not negligent, if he was acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, merely because there is a body of another opinion that takes a contrary view; (ii) that when a doctor was dealing with a mentally sick man and had a strong belief that his only hope of cure was submission to electric convulsive therapy, the doctor could not be criticized if believing the dangers involved in the treatment to be minimal, he did not stress that to the patient; and (iii) that in order to recover damages for failure to give warning the plaintiff must show not only that the failure was negligent but also that if he had been warned he would not have consented to the treatment. Accordingly, Bolam principle has formulated the rule 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.

159 Reibl v. Huges (1980) 2 SCR 880
160 Supra, n. 143
161 Supra, n. 68
Again the majority of the House of Lords\textsuperscript{162} held that the test of liability in respect of a doctor’s duty to warn his patient of risks inherent in treatment recommended by him was the same as the test applicable to diagnosis and treatment, namely that the doctor was required to act in accordance with a practice accepted at the time as proper by a responsible body of medical opinion. Lord Scarman\textsuperscript{163} has laid down the following proposition: ‘The English law must recognize a duty of the doctor to warn his patient of risk inherent in the treatment which he is proposing; and especially so if the treatment be a surgery. The critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient’s position would be likely to attach significance to the risk. Even if the risk be material, the doctor will not be liable if on a reasonable assessment of his patient’s condition he takes the view that a warning would be detrimental to his patient’s health.”

The dictum of the House of Lords\textsuperscript{163} with regard to duty of the doctor to warn is that although a decision on what risks should be disclosed for the particular patient to be able to make a rational choice whether to undergo the particular treatment recommended by a doctor is primarily a matter of clinical judgment, the disclosure of a particular risk of serious adverse consequences might be so obviously necessary for the patient to make an informed choice that no reasonably prudent doctor would fail to disclose that risk. Moreover, when the question especially by a patient of apparently sound mind about the risks involved in a particular treatment is proposed, the doctor’s duty is to answer both truthfully and as fully as the questions require. The view of the Apex Court of the Australia is that the question whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment does not depend on medical standard or practice. This is a question for the court to decide, and the duty of deciding it, cannot be delegated to any professional or group in the community. A doctor has a duty to warn the patient of material risk inherent in the proposed treatment, and it does not depend upon medical standards or practice. That is a

\textsuperscript{162} Ibid.

\textsuperscript{163} Ibid.
question for the court to decide, and the duty of deciding it cannot be delegated to any profession or group in the community. This duty is subject to the therapeutic privilege ie, and opportunity offered to the doctor to prove that he or she reasonably believed that disclosure of a risk would prove damaging to the patient.

The duty of disclosure is subject to therapeutic privilege enabling the doctor to withhold information where disclosure would have posed a serious threat of psychological determent to the patient. The clinical assessment of the patient’s condition may justify the withholding of information in cases where the patient is too ill to assess the information properly. These are the different aspects of advice, information and warning. Development of law relating to diagnosis and treatment is relevant in this context.

I. Diagnosis and Treatment

An error of clinical Judgment does not always amount to negligence. Whether an error of clinical judgment amounts to negligence depends on the circumstances of each case. Lords in White house v. Jordan has observed, “merely to describe something as an error of judgment tells us nothing about whether it is negligent or not.

The true position is that an error of judgment may not be negligent, it depends on the nature of the error. If it is one that would have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care, might have made, then it is not negligence.
Later Lord Edmund Davies\textsuperscript{164} pointed out as follows. “To say that a surgeon committed an error of clinical judgment is wholly ambiguous, for, while some such errors may be completely consistent with the due exercise of professional skill, other acts or omission in the course of exercising clinical judgment may be so glaringly below proper standard as to make a finding of negligence inevitable”.

Again Lord Clyde has observed in “\textit{Hunter v. Hanely}, \textsuperscript{165} in the realm of diagnosis and treatment, there is ample scope for genuine difference of opinion. A man is not negligent merely because his conclusion differs from that of other professional men. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure of, if acting with ordinary care.” This was the stand of English court with reference to diagnosis and treatment.

The position in India is more or less the same. The National Commission\textsuperscript{166} established in India under Consumer Protection Act 1986 is also of the view that a doctor cannot be found to be negligent merely because in a matter of opinion he made an error of judgment. In \textit{Rajeev Kumar’s case}\textsuperscript{167} the doctor was not held negligent for giving treatment to the patient for about ten months by making wrong diagnosis of gastric ulcer, because the ultra sound report of pelvic area disclosed in the investigation and symptoms narrated by the patient were not indicative of diagnosis of recurrent appendicitis from which the patient was really suffering.

The law laid down by the Supreme Court of India,\textsuperscript{168} is that medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient and it would be difficult to hold the doctor guilty of negligence, as long as

\begin{center}
\textsuperscript{164} \textit{Ibid}
\textsuperscript{165} \textit{Supra}, n. 70
\textsuperscript{166} Dr. N.T. Subrahmanyan v. Dr. B.Krishna Rao, 1992 (2) CPR 247 NC
\textsuperscript{167} 1993 (3) CPR 248 NC
\textsuperscript{168} Achutra Haribhau Khodwa v. State of Maharashtra (1996) 2 SCC 634
\end{center}
the doctor acts in a manner acceptable to the medical profession and the court finds that he had attended on the patient with due care, skill and diligence.

In *Maynard v. West Midlands Regional Health Authority* two consultants thought that the cause of chest complainant of the patient was due to tuberculosis or Hodgkin’s disease. The consultants decided to perform an exploratory operation to determine whether she was suffering from Hodgkin’s disease before obtaining the result of test to determine the disease tuberculosis. As a result of the operation, the patient suffered damage to a nerve affecting her vocal cord, which caused her speech to be impaired. The diagnosis of tuberculosis was confirmed subsequently. The allegation against the consultants was that they had been negligent in deciding to carry out the operation before obtaining the result of the tuberculosis test. The House of Lords did not hold the consultants negligent for committing error of judgment in taking the decision to operate on the patient, because the decision to undertake the operation of the patient was in accordance with the responsible body of medical opinion. A medical practitioner owes a duty to diagnose his patient’s condition. The duty of a doctor is not only to make enquiries in ascertaining the necessary data, but also to exercise reasonable professional skill in forming a conclusion from such data. Failure to exercise due skill in diagnosis as a result of which wrong treatment was given was held to amount to negligence. A competent medical practitioner must know when a case is beyond his skill. It is the basic duty of the doctor either to call in a more skilful person or to advise the removal of the patient to the place where skilled treatment is available. These are the various concepts of liability arising out diagnosis and treatment. The next area where liability may arise for the medical professional is while dealing with emergency treatment.

---

169  1984 (5) All ER 135
a. Emergency treatment

A doctor can lawfully operate on or give other treatment to adult patient who is incapable of consenting to his doing so, provided that the operation or treatment is in the best interest of such patients. The operation or treatment will be in their best interest only if it is carried out in order either to save their lives or to ensure improvement or prevent deterioration in their physical or mental health.\(^{171}\) It is clear that in cases of emergency or unconsciousness all consideration regarding consent will be set aside and doctor will do whatever, is necessary to save the life of a patient, infant or adult, to save him from permanent disability or from unnecessary pain and suffering. Lord Donaldson, MR in Canada, the Nova Scotia Supreme Court\(^{172}\) has settled the law by stating in the ordinary case where there is an opportunity to obtain the consent of the patient, consent must be obtained. If there is no consent-express or implied, and the conditions which have been discovered make it imperative on the part of the surgeon to operate, then he will be entitled to act without consent, It is well-settled in Canada\(^{173}\) that if an operation is necessary as opposed to convenient, for the protection of the life or preservation of the health of a patient, a doctor is justified in proceeding without consent.

In America, SCOTT J., observed \(^{174}\) that when emergency arises and a surgeon finds that some action must be taken immediately for the preservation of the life for health of the patient, it is impracticable to obtain the consent of the ailing or injured one or anyone authorized to speak for him. In such a case it is the duty of the surgeon to perform such operation even without such consent. The principle of law enunciated in America\(^{175}\) is that the discretion to be exercised by the physician for the welfare of his patient in a case of emergency should not be interfered with. If a person is injured to the extent of rendering him unconscious and his injuries

\(^{171}\) F v. West Berkshire Health Authority, [1989] 2 All ER.545.
\(^{172}\) Ibid
\(^{174}\) Murray v. Mc Murchy [1949] 2 DLR 442
\(^{175}\) Ibid.
require prompt surgical attention, a medical man called to attend him will be justified in applying such medical or surgical treatment as may reasonably be necessary for the preservation of his life or limb, and the consent on the part of his patient will be implied in such circumstances.

The up short of the above discussion is that the doctor has authority to give such treatment as is necessary for the best interest of the patient in an emergency without his consent, whether this authority is based on the principle of “implied consent” or “agency of necessity”. The Consumer Court in India 176 did not hold the surgeon guilty of negligence for exercising his discretion to remove the uterus of the patient without consent when she was operated for removal of pus in the abdomen. The next aspect is the development of law relating to treatment of mentally ill person.

b. Treatment of mentally ill person

Mentally ill person means a person who is in need of treatment by reason of any mental disorder other than mental retardation.177 McCullough J, 178 declared the treatment as unlawful given by the psychiatrist in good faith, but without consent of the patient suffering from chronic schizophrenia. It is observed that in the absence of clear statutory authority to the contrary if one is to be detained in a hospital, or under the medical treatment, or to be submitted to medical examination without his consent, is valid, if it is for the welfare of patient. So the medical treatment of patient suffering from mental disorder is governed by the normal rules of consent. These rules serve to prevent the doctor from giving treatment against the will of the patient suffering from mental illness, but the medical practitioners may be in a predicament where the patient is incapable of understanding the nature of the

176 Arun Kumar Mishra v. Dr. Parshottam Singh, 1998 (3) CPR 284 (pat) : 1998 CPJ 773 (C) SCDRC
177 Section 2(1) of the Mental Health Act 1987
178 R.v. Hallsstram exparte, [1986] 2 All ER.
procedure of proposed treatment. In 1989, the House of Lords 179 considered for the first time the legal basis on which a doctor or surgeon may lawfully treat someone who is unconscious or mentally ill to give a valid consent where there is no surrogate decision maker available. In common law a doctor can lawfully operate on or give other treatment to adult patient's who are incapable of consenting to his doing so, provided that the operation or treatment is in the best interest of such patients. Another relevant area is with respect to law relating to treatment of children.

c. Treatment of Children

In England, the Family law Reform Act, 1969 180 provides that the consent of a minor who has attained the age of 16 to any surgical medical or dental treatment which, in the absence of consent would constitute a trespass to his person, shall be as effective as it would be if he were of full age, and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent to it from his parent or guardian. There is no analogous provision of law in India. However under the common law the natural guardian has power to do all acts which are necessary or reasonable and proper for the benefit of the minor. In the absence of the natural guardian the District Court is authorized to appoint the guardian for the welfare of the minor in accordance with the law to which the minor is subject, and such guardian must look after the health of minor.181

In India, the pregnancy of minor woman cannot be terminated except with the consent in writing of her guardian. 182 In Gillick case 183 the unanimous opinion of the House of Lord is that a minor can give a valid consent to Medical treatment

179 Supra n 171
180 Section 8 (1) Family Law Reform Act.
181 Section 4 and 6 of the Hindu Minority and Guardianship Act,1956.
182 Section 3 (4) of the Medical Termination of Pregnancy Act, 1971
183 Gillick v. West Norfolk and Wisbech Heath Authority, [1986] AC 112; [1985] 3 All ER 402
without the knowledge and consent of the parents. If the minor is capable of sufficient intelligence and power of understanding about the procedure of proposed treatment. It is pertinent to point out that a child witness is competent to testify if he is capable of understanding the question put to him, and giving rational answer to those questions.\textsuperscript{184}

In another case a child was born with a life threatening liver defect. The pediatrician expressed the view that the child would be likely to have many years of normal life by a liver transplant. The mother refused to give her consent to the operation. Under wardship jurisdiction the judge granted permission for the operation in the best interest of the child. By reversing the decision it is held by the Court of Appeal\textsuperscript{185} that in the instant case the welfare of the child depended on the mother, her views were relevant and trial judge had erred in deciding that mother’s decision was unreasonable in the light of the unchallenged clinical opinion in favour of the operation. Another relevant area is mistaken diagnosis.

**J. Mistaken Judgment**

Another area of liability for the application of negligence is mistaken judgment. A physician or surgeon has to be very accurate in his judgment in diagnosis, in treatment or in the operation theatre. Even a slight error of judgment, misadventure or mistaken diagnosis, will not make him liable for negligence always. Medical science by its latest techniques and methodology has minimised the risk to the health of human beings but science of medical knowledge has not eliminated and cannot eliminate them completely. Some risks with the best of intelligence and ability of medical men are inevitable due to errors of Judgment or misadventure. As Lord Denning J says: “It is easy to arise after the event and to condemn as negligence that which was only a misadventure. Every surgical operation has a risk factor. We cannot take the benefits of the profession without taking the risks.”\textsuperscript{186}

\begin{flushright}
\textsuperscript{184} Section 118 of Indian Evidence Act\textsuperscript{.}
\textsuperscript{185} Supra, n. 29
\end{flushright}
Again in the malpractice cases, it is the duty of court to collect evidence of experts to determine whether in a particular case the conduct of indicted practitioner was negligent. If yes then it is actionable. It would be most illogical and something contrary to the commonsense that the doctor should be held liable even for smallest fault from their part. But doctor must be very careful regarding every reasonable apprehension of negligence. In this connection, the following observation of Lord Denning in *Hatcher v. Black* is relevant “a doctor examining a patient, or a surgeon operating at a table, instead of getting on with his work would be safer looking over his shoulder to see if some one was coming up with a dagger, for an action for negligence against a doctor. ’’

K. Determination of Negligent Conduct

In determining whether a party is negligent, the standard of reasonable care is that which is reasonably to be demanded in the circumstances. Standard of the reasonably prudent practitioner is the criteria on which the conduct is to be measured. The degree of care is subject to variations according to several factors, eg, magnitude of risks, probability of likelihood of injury, gravity or intensity of injury and the locality where the injury is caused etc. The following are the legal components for determination of negligent conduct.

For determination of negligence the legal standard dictated by each judge is different. Lord Scarman applied the ‘Prudent patient’ or ‘reasonable patient’ test. The remaining judges have affirmed the ‘reasonable doctor’ standard. Lord Diplock stated that the court has to determine its application on the basis of evidence of accepted practice as in Bolam.

187. [1997] 1 All ER 906
Another contribution to the area of negligence was by Lord Templeman. Lord Templeman’s Speeches are idiosyncratic. He does not refer to the *Bolam* test or indeed, the ‘prudent patient’ test at all. Four key features of his speech are as follows. First, a doctor is not entitled to determine absolutely what information a patient should be provided but, equally, a patient is not entitled to know everything. Secondly, a patient is entitled to such information as is necessary for him to make a ‘balanced judgment’ whether or not to consent to the treatment. Thirdly, a doctor as a clinical practitioner has a freedom determining what information should be given and in what terms it should be couched. Finally, in fulfilling his duty a doctor should provide information sufficient to alert the patient to the general dangers in the procedure.

Lord Templeman’s speech cannot be understood and is riddled with internal inconsistencies and contradictions. The next change in the development of law was brought about by Lord Diplock in *Sidaway*. He suggests an expansion of the doctor’s duty to disclose information.

First, it may well be that the courts will expand the doctors duty to answer questions. The initial response of the courts in such a case was not encouraging. The court of appeal relied upon *Bolam* to determine the standard of disclosure not withstanding the data in *Sidaway*. In *Pearce v. United Bristol Health NHS Trust*, Lord Woolf MR stated that if a patient asks a doctor about the risk, then the doctor is required to give an honest answer. If he did not, the implication is clear.

Secondly, some judges have interpreted the *Sidaway* decision more creatively than it was done in court of appeal in Gold. By synthesizing the speeches of Lord Bridge and Lord Templeman, the court have concluded that the doctor’s duty to volunteer information is not solely a matter for a professional practice.

188 See, Kennedy, Treat Me Right (Select Bibliography), at pp.74-561.
189 *Supra*, n.79.
190 (1998) 48 BMLR 118 at p.120.
191 *Gold v. Horingey Health Authority*, [1987] 2 AllER.888
The Third development is linked to the previous one and may have been part of the judge’s reasoning in Smith itself. The House of Lords in *Bolitho v. City and Hackney HA* re-interpreted the so-called ‘Bolam test’. Following the approach developed in the court of appeal, the House of Lords held that *Bolam* itself left room for Judicial examination of medical practice and medical evidence. Neither was conclusive of the standard of care expected of doctor. A court always had a final say on whether a breach of duty had occurred. The *Bolam* test required that the accepted practice of the medical profession should be ‘responsible, reasonable, and respectable’. It must have a ‘logical basis.’ The expert must direct their minds to all the relevant factors and reach a defensible conclusion.

In *Bolitho*, the House of Lords was only concerned with cases of medical negligence arising out of diagnosis and treatment. Lord Browne-Wilkinson specially excludes information cases. Lord Bridge took a step beyond *Bolam*: where disclosure of the risk was ‘so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to disclose it. There is even common ground here with the Lord Templeman, who requires the doctor to provide information in order to allow the patient to make a ‘balanced judgment.’ Lord Diplock also, in applying *Bolam*, refers to the need for the practice to be responsible. So the ‘reasonable’, ‘responsible’ oversight was demanded in *Bolitho*. Sir John Donaldson MR spoke of a practice ‘rightly’ accepted by the medical profession. In *Sidaway* and *Bolitho*, Lord Woolf MR stated as follows:

“Obviously the doctor, in determining what to tell a patient, has to take into account all the relevant consideration, which includes the ability of the patient to comprehend what he has to say to him and the state of the patient at the particular time, both from the physical point of view and emotional point of view. Where there is what can realistically be called a ‘significant risks’, then, in the ordinary event…. the patient is entitled to be informed of that risk.”

---

192 Ibid
193 Supra, n.75
194 Ibid
195 Supra, n.79
By considering all these aspects it is better to provide patient with as much information as possible prior to treatment. This is the present perspective of law relating to determination of negligent conduct. The meaning of foresight is another relevant area of medical negligence offence.

L. Foresight

Medical practitioner ought to have reasonable anticipation of the risks involved in the path adopted by him. He is expected to have extraordinary foresight, but he must anticipate those hazards which any reasonably prudent doctor could foresee. Where he anticipates greater hazards, he must take greater care to overcome those risks. Reasonable foresight is also to be decided in the light of medical knowledge at that time. But if a doctor anticipates hazards he need not avoid treatment of patient but he may choose different treatment, wherein lesser risks is involved. This can be considered as a safe way for the proper exercise of standard of care.

The notion of duty is sometime used in a separate and non specific sense, namely that for there to be duty of care in particular case the harm in question must have been foreseeable to the individual claimant. In Bourhill v. Young Wright the court explained that foreseeability is always relative to the individual affected. This raises a severe additional difficulty in the cases where it has to be determined not merely whether the act itself is negligent against someone but whether it is negligent Vis-à-vis the plaintiff.

Again foreseeability is one part of the concept of breach of duty. A breach of duty also arises where the conduct of the defendant is ‘unreasonable’ in the sense of failing to reach the appropriate standard of care. This will be the standard of normally careful behaviour in the profession, occupation, or activity in question. In applying this standard in what is sometime a rough and ready way, the courts

---

196 Supra, n.45
199 Latimer v. AEC Ltd, [1953] AC 643
frequently balance the degree of foreseeability or risks of harm. Negligence as a state of mind, distinct from both intention and recklessness, denotes the failure to foresee the consequence of one’s action in terms of the risk of harm they create to others. While negligence in this sense is a necessary condition of liability in tort it has the existence of a causal link between the defendants’s lack of care and the resulting damage. It is not only necessary to assess whether the damage in question is of a type, which the courts recognize as recoverable in principle (duty), but also whether the defendant could have avoided the harm by taking precaution, which the law regards, in the circumstances, as an acceptable burden. Another aspect is the magnitude of risk involved in medical profession.

**M. Magnitude of Risk**

Magnitude of risk is evaluated thought in different ways. Standard of care of medical man had also bearing on the quantum of risk involved. Where more risk is involved, more care and skill is required. The degree of care required varies directly with the risk involved. Those who are engaged in operation inherently dangerous must take precaution, which is not required of person engaged in the ordinary routine of daily life.\(^{200}\) Thus in a major surgical operation where the risk is greater, the surgeon must be extraordinarily careful.

Whatever be the status of the medical man, be he the general practitioner, specialist or intern, the degree of a care required varies in proportion to the magnitude of the risks involved. More extensive precautions must be taken in the treatment involving risks known to the medical profession than where no such risks can reasonably be anticipated.\(^{201}\) By risks we mean not only those risks which are known to the practitioner whose conduct is in question but also those risks which were known or ought reasonably to have been known to the ordinarily skilled and prudent practitioner of his class. Medical man cannot be excused on the plea that there were little risks and hence no need to take greater care. Where the risks could

\(^{200}\) *Glassgow v. Muir*, [1943] AC 448 per Mac Million Lord

\(^{201}\) *Ibid.*
ordinarily be characterized as negligible failure will be compatible with the exercise of proper skill and care. Another component is probability of injury.

N. Probability of Injury

The probability of injury is also one of the factors in determining the duty of care. Where there is likelihood of injury, the doctor must be careful accordingly. If a particular treatment is given or operation is performed, injury or hazards are likely to follow. This element must be taken into account while treating a patient. For example, injection of procaine penicillin, has the tendency of reacting on the people in general and every ordinary medical practitioner can anticipate this risk. Taking into account this likelihood of effect on the people, doctor ought to be careful, ie, he must first of all administer a testing dose before injecting the drug. Only those probabilities of injury will give rise to legal action, which can be reasonably anticipated. For example, he may not be liable for the side effect of life saving drugs. So cause of negligence can be focused on reasonable probabilities but they are not bound to guard against fantastic possibilities. Another component is severity of consequences. The severity of consequences is a countable factor of medical negligence.

O. Severity of Consequences

Severity of consequence also deserves consideration in judging the conduct of medical men, that is to know whether his conduct was reasonable or not. There is no valid reason for excluding as irrelevant the gravity of the damage if an accident occurs. Where damages are of grave nature, greater precautions are required. If the damages are of high consequences, a higher standard of care shall be expected. Another component is the importance of the object of treatment; this can be considered as a relevant factor in comprehending a medical negligence offence.


203 Paris v. Stepney, (1951) AC 356,375

204 Ibid.
P. Importance of the Object

It is the importance of the object sought to be achieved by doctor at the cost of running the risk, which is relevant factor in determining the liability of the medical man. In practicing medicine every medicine or every treatment is not suitable to every person. There may be side effects or allergic effects of medicine unless it is administered with proper care and skill. If light medicines are given the treatment may take longer time without any risk, on the other hand if strong medicines are given they will cure the disease very promptly, but may adversely affect the physique of a patient. Now it is the duty of doctor to opt the right path by striking a balance between the treatment and risk involved.

As Lord Dinning L.J,\textsuperscript{205} rightly said, in measuring due care you must balance the risk against the measures necessary to eliminate the risk. To that proposition, there ought to be added the need to balance the risk against the end to be achieved. The same thing is stated in a very picturesque manner by Asquith j: “If all the trains in this country were restricted to a speed of five miles an hour, there would be fewer accidents, but our national life would be intolerably slowed down. If the purpose to be served is sufficiently important, it will justify the assumption of abnormal risks.”\textsuperscript{206} Where there is exorbitant high speed of risk there arises the concept of negligence if it causes damages. The locality can be considered as the significant component of medical negligence offence relating to standard of care.

Q. Locality Rule

The situation or locality where medical man is placed is an important factor. In spite of all diligence and skill he may be helpless because things are beyond his control. Even with all the best efforts and good intentions, things may go

\textsuperscript{205} Watt v. Heartfordshire County Council, 1954 2 All ER 371

wrong because in the location where he happened to be, he could not do, what was needful or what could be done in a well equipped hospital or a nursing home. The locality rule was evolved in 1880 for the first time by the Supreme Court of Massachusetts in Small v. Howard.\textsuperscript{207} Supreme court observed: the doctor was bound to possess that skill only which physicians and surgeon of ordinarily ability and skill, practicing in similar localities, with same opportunities and with similar experience ordinarily possess.

In the above dictum the expression practicing in similar localities is most important. We cannot expect that the same degree of skill and care from a physician who is practicing in a remote village, which we could expect from a physician in metropolitan city with a well-equipped nursing home. Locality rule was justified when transportation was different, medical school and hospitals were often inaccessible and doctors licensed to practice had little or no formal training. It is therefore submitted that court may take into account locality rule in measuring the standard of care of the medical practitioner, in the context of indigenous conditions of India. Another issue relates to proximate cause of injury.

\textbf{R. Proximate Cause of Injury}

For creation of tortious liability, plaintiff must prove that the negligent conduct of the medical practitioner was the proximate cause of the injury suffered by the plaintiff patient. Many times the patient goes in for self-medication or get treatment from quacks or unqualified medical practitioners who administer the medicine, without caring for their side effect, consequence and suitability to the patient. When the condition of patient starts deteriorating or the disease reaches a serious stage the patient are abandoned or advised to consult some specialist or qualified doctor, but the latter being ignorant of previous prescription starts his treatment afresh. If previous medicine shows adverse effect on the patient the latter doctor’s prescription is not the proximate cause of injury to the patient and that doctor need not be held liable in such cases. Problem may arise if several possible

causes for the injury are shown, only one of which is attributable to the doctor, and the evidence does not establish that any of the alleged causes is actually responsible for the injury. This difficulty usually occurs because the plaintiff’s expert medical witnesses are reluctant to state outright that the defendant’s act was the cause of negligence in resulting injury. It is because of this that the plaintiff fails to prove that the act complained of was a proximate cause of injury. Law does not demand the doctor’s negligence to be the sole or only proximate cause in order to enable the plaintiff to recover damages.

House of Lords discussed the question of causation at length. They posed a question whether cause of plaintiff’s injury was his fault or health authority’s negligence. They averred that the question is to be decided on the balance of probabilities given in the plaintiff’s condition when he firstly arrived at the hospital, even correct diagnosis and treatment would not have prevented the disability from occurring, allowed the appeal of health authority, because before the duty arose, the damage complained of had already been sustained or had become inevitable. Traditionally courts have formulated the physician’s standard of care to stipulate that the physician must exercise the degree of skill of practitioner in the community in which the physician practices. Another most relevant matter is consent doctrine.

S. The Consent Doctrine

The law relating to consent doctrine is the most relevant area of medical liability. In the words of Justice Cardozo, ie, “every human being of adult years and sound mind has the right to determine what should be done with his body and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages.” Consent principle is a complicated area which needs more explanation. So consent doctrine may be discussed as follows.

208. Hoston v. East Berkshire Area Health Authority, [1987] 2 All ER 909 the plaintiff injured his hip in a fall. He was taken to a Hospital run by the defendant health authority, where injury was not diagnosed correctly. After 5 days of severe pain his injury caused permanent disability at the age of 20. The plaintiff claimed damages for breach of duty.
(a) Necessity for Consent

The necessity of consent is most relevant area for the determination of negligence in the case of a medical negligence offence. A doctor is required, as part of his duty of care to his patient, to explain what he intends to do, and the implication involved, in the way in which a responsible doctor in similar circumstances would have done, and if there is a risk of misfortune inherent in the procedure, however well it is carried out, the doctor’s duty is to warn of the risk of such misfortune. 209 The obligation to disclose risks of electric medical procedure such as sterilization and cosmetic surgery depends on the normal negligence principle of accepted professional practice. 210 The consumer court in India 211 held the surgeon guilty of negligence for conducting sterilization operation during caesarian section without obtaining consent, particularly when there was no urgency for sterilization operation. Another relevant area is the difference between Battery and negligence.

b Difference Between Battery and Negligence

The doctrine of consent is the distinguishing factor of battery and negligence. Battery is an intentional tort. There are mainly three differences between battery and negligence. First, battery is a tort actionable persee, so the claimant need not prove that he suffered any harm. In negligence, by contrast damage is an element of the tort and without it the action will fail. Secondly, the burden of proof might be different in torts. The onus of proof is on the patient and so it is for him to prove that he did not consent to the treatment. 211 If this (which, incidentally, favours the doctor) prevails, then the evidentiary burden of proof in battery and negligence will be on the claimant. More significant is the third difference, which comes under the general heading of causation. The test of remoteness is also different in these two torts. For battery is an intentional tort and intended consequences are never remote.

210 Ibid.
211 Ibid.
Finally, the payment of damages may be affected upon whether the action was framed in negligence or battery. Under Indemnity Scheme, which came into effect on first January 1990, health authorities were required to take responsibility for claims against their employees/doctors. Such scheme was limited to claim for ‘medical negligence’ and excluded claims for battery. The same appears to be true for the Clinical Negligence Scheme for Trusts (CNST) introduced in England. It was restricted to ‘clinical negligence’ claims which arise from ‘breach of duty of care.’ It seems that this phrase bears its ‘legal meaning’ and hence excludes battery. The solution may be even a claim framed in battery which satisfies all the elements of negligence and so be treated as falling within the scheme. Another relevant area is proxy consent and consent of minors.

c  Proxy Consent and Consent of Minor

It is only of true value when the patient has given express authority to another person to give or withhold consent on his behalf or when the law invests a person with such power. The most common example of the latter case would be that of parent and child. Another most relevant issue is the law relating to informed consent.

d  Informed Consent

Informed consent is a rule in medical negligence. Prior consent is necessary in case of medical interference to the body of patients. Doctor should inform the details regarding disease and mode of treatment. Consent of treatment is a mandatory basic requirement of medical practitioner, otherwise, it can be considered as battery.


Ibid.
Position in America

The notion of an informed consent had been identified some time earlier in America;\(^\text{214}\) it was not until the celebrated decision of *Canterbury v. Spence* in 1972 that informed consent was fully articulated as a legal doctrine.\(^\text{215}\) The Canterbury decisions represent a milestone in the history and evolution of the pre-treatment duty to disclose medical information, largely because it clarified development which had taken root at the turn of the century but which had begun to result in uncertainty and inconsistency throughout the States.

Another finding by Robinson J in *Canterbury v. Spence*\(^\text{216}\) was “Respect for the patient’s right to self – determination on particular therapy which demands a standard set by law for physician rather than one which physician may or may not impose upon themselves. The patient’s right to self – decision shapes the boundaries of the duty. It also laid down the following aspects regarding the law of consent:

The unlikelihood of there existing within the medical communities any meaningful “Professional consensus on communication of the opinion and risks information.”

(1) The fact that “the myriad of variables among patient makes each case so different that its omission can rationally be justified only by the effects of its individual circumstances.”
(2) The danger that “no custom at all may be taken as affirmative custom to maintain silence.”
(3) The very real danger that expects “many state merely their personal opinions as to which they or others would (disclose) under given condition” and

\(^{214}\) Rather ironically, the phrase informed consent was coined in an amicus curia (or friend-of-the-Court brief) submitted by the American College of Surgeons to the California Court of appeal in *Salgo v.Leland Standford Jr. University Board of Trustee* 154 Cal.App.2d 560,317.

\(^{215}\) Supra, n. 158

\(^{216}\) Ibid.
(4) The inevitability that a professional standard would “arrogate the decision on revelation to the physician alone.”\textsuperscript{217}

_Canterbury v. Spence_ was a relatively natural judicial response to malpractice developments that had tentatively taken root in America at the turn of the century but had continued in a confused and incoherent manner until that landmark decision. After a series of decisions in _Schloendoooff v. Society of New York_ \textsuperscript{218} Hospital Judge Cardozo memorably declared “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault for which he is liable in damages.” In _Wall v. Brim_ \textsuperscript{219} U.S. Court again came to a finding that “a surgeon may not perform an operation different in kind from that consented to or one involving risks and results not contemplated.’ Some courts had treated mistake or inadvertent deviation from consent term as instances of unauthorized treatments (attracting liability in battery) without finding any intention to do on the part of the physician. Others had treated such scenarios as actually or potentially falling under either battery or negligence.\textsuperscript{220}

Judicial attention gradually turned to negligence as a more flexible and acceptable forum for determining disclosure duties. Washington Court of Appeals decided that the court does not require expert testimony for its verdict where the necessity of information would be obvious to the layman.\textsuperscript{221} Robinson J further recognized that the views of medical experts will be required where the doctors attempt in his defense to justify non-disclosure on ground of necessity (Circumstances of Urgency) or of therapeutic privilege, which both acknowledge that “as important as in the patient right to know, it is greatly out – weighed by the magnitudinous circumstances giving rise to the privilege.”\textsuperscript{222} It was followed in

\begin{itemize}
\item \textsuperscript{217} _Ibid_ at pp.783,784
\item \textsuperscript{218} N.Y.125 (1914) Vol. 211 at 129.105.
\item \textsuperscript{219} 138 U S R (1943) at p.138
\item \textsuperscript{220} Estrada v. Orcoitz 75 cat App 2d 54-176 p. and Moos v. United State 118F Supp.275 (1954)
\item \textsuperscript{221} Hunter v. Brown 4 Wash App 899,844 U S R (1971) 1162
\item \textsuperscript{222} Supra, n.158
\end{itemize}
Canterbury v. Spence and in other subsequent decisions. Many states legislated to ensure that patients received certain information for designated treatments such as sterilization, electro convulsive therapy, breast cancer treatments, and for administration of certain drugs.  These did not address financial compensation but instead targeted compliance by doctors so that patient would undergo certain treatment only with full knowledge of their benefit-risk ratios.

In some North American States, informed consent seems not to have adversely affected its acceptance in other common law jurisdiction. The Canadian Supreme Court delivered a sophisticated analysis in its Landmark decision in Reibl v. Hughes prior to that decision, vigorous standards of disclosure had been sanctioned by law, the breach of which had resulted in the finding of battery. In Reibl v. Hughe, however, the Supreme Court of Canada aligned itself with the negligence analysis, and distanced itself from informed consent as a descriptive legal concept on the basis that it tends to blend the legal distinctions between trespass and negligence. Of that distinction, Laskin C.J proposed that “battery action should be restricted to cases where the defendant intervenes without a clarity beyond a patients consents, and that the duty to disclose medical information to patient more properly” arises as the breach of an anterior duty of care, comparable in legal obligation to the duty of due care in carrying out the particular treatment to which the patient has consented. The disclosure of information involves no special skill: “Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patients apprehended capacity to understand that information.” This latter, according to Gaudron J. tends to be a matter

---

223 Sterilization is subject to federal regulations in the Code of Federal Regulations 42, part 50, adopted under the United States Public Services Act. These require a 30 day warranty period between first consultation and treatment, and they specially demand that obstacles of medical treatment.


227 Supra, n. 224

228 Kinny v. Lockwood, (1931) 4 U S R.p.1
“of simple common sense” which does not call for any technical expertise beyond the comprehension of the court. In Truman v. Thomas,\(^{229}\) the Supreme Court of California recognized a duty on doctors to obtain informed refusal and found a gynaecologist liable for the death of a woman who had refused to agree to a cervical smear, which would have revealed her cancer at a late stage. Bird C.J emphasized the inequality of the doctor-patient relationship, the patient’s reliance on the doctor for information and elucidation and the resulting obligation on the physician to ensure that clinical decision-making is not made at arms length.

The American experience reveals that lawyers and doctors have overwhelmingly believed the main function of consent is to protect against liability.\(^{230}\)

Later in In Kelly v. Hazlett, Morden J\(^ {231}\) explained that informed consent is necessary to obtain patients “awareness and assent.” Informed consent Doctrine is a direct and unfortunate by-product of its roots in the early cases of trespass and unauthorized treatment. In England the concepts of medical negligence was focused on Bolam v. Friern Hospital,\(^ {232}\) where it was stated that “doctor is not guilty of negligence if he has acted in accordance with practice accepted as proper by a responsible medical man skilled in that particular art.”\(^ {233}\)

The progress of the consent doctrine has been described by North American writers as a ‘tempest’. Certainly, the history of its development in the United States has shown remarkable inconsistency, leading in many cases to absurdities and encouraging medical malpractice litigation unduly.\(^ {234}\) It has undoubtedly resulted in greater sensitivity on the part of the American medical profession to the need to inform patients of the implication of treatment but this

\(^{229}\) Truman v. Thomas (1980) U S R p.611

\(^{230}\) Supra, n. 223

\(^{231}\) (1976) 75 DLR (3d) 356,555,556.

\(^{232}\) Supra, n.143


\(^{234}\) Ibid.
positive result has only been achieved at the price of heightened distrust and increase in the practice of legalistic and defensive medicine. It is unlikely that the consent doctrine will be as widely used in British Courts as it has been in the United States. The line has now been clearly drawn on the issue of the battery/negligence distinction and that undoubtedly restricts the scope of consent actions. In addition, reliance on expert evidence is likely to continue which means that the movement towards the patient-oriented approach, which is evident in the recent Canadian decision, is likely to occur.

To be valid, the consent must be real. Once the patient has been informed in broad terms of the nature of the intended treatment and gave his consent, the patient could not say that there had been lack of real consent. Consent is not valid if it is obtained by fraud or misrepresentation as to the nature of the procedure consent is also vitiated by undue influence or threat of violence. The court of law may test the reality of a consent critically if the doctor stands in a position of authority over the patient as in the case of a prisoner and prison medical officer.

Although not absolute in every instance. Some of the responsibilities of physician or surgeon towards a patient include a duty to

1. Fully inform a patient of her condition.
2. Notify a patient of the results of a diagnosis or test.
3. Inform the patient of the need for different treatment or refer the patient to a specialist or other qualified practitioner.
4. Continue medical care until proper termination of the relationship.
5. Give proper notice before withdrawal and treatment

_________________________________________________________________________

235 Allan v. New Mount Sinai Hospital (1986) 28 All ER.
6. Not to abandon a patient, and making arrangement for treatment
during absences.

7. Treat non-paying patients the same as those who pay.

8. Use diligence in treatment and in providing all necessary care.

9. Obtain a patient's informed consent before performing a medical
Procedure.

10. Instruct others as to the care and treatment of a patient.

11. Warn other about the exposure to communicable and infectious
disease.

A patient has a duty to cooperate with a physician and
participates in treatment and diagnosis. For example, patient does not have
a general duty to volunteer unsolicited information but is required to
disclose a complete and accurate medical history upon questioning by a
physician. A patient also must return for further treatment when required.
Failure to co-operate or participate in treatment may result in a limited
recovery or completely bar recovery, depending on circumstances of the
case. The Law of consent has some vital importance with regard to the basic
principle of tort law. In England an adult patient is invariably said to have
complete autonomy over his body to the extent that he can consent to any
form of medical treatment and no one can veto that consent. Before treating
a patient, the health carer must ensure that he has the patient’s express or
implied consent. This can be given verbally, in writing, or a combination of
the two.

237. For a statutory example where consent must be in writing—See Human
Fertilization and Embryology.
It is now well-settled law that a consent, which is not properly informed, is not a real consent. An apparent consent may be vitiated due to failure of the doctor to make proper disclosure of risks inherent in the procedure consented to. There is no obligation on the doctor to canvas to the patient anything other than the inherent implication of the particular operation he intends to carry out. Once the patient had been informed in broad terms of the nature of intended treatment and had given his consent, the patient could not say that there had been a lack of real consent. The legality of what the doctor ought or ought not to tell his patient about the risk of the proposed procedure of treatment will be judged by the tenets of accepted professional practice. Failure to make adequate disclosure of the proposed liability for committing unlawful battery.’ Bristow, J. dictates, “when the claim is based on negligence the plaintiff must prove not only the breach of duty to inform but also that the duty had not been broken. Once it is shown that the consent is unreal, and then what the plaintiff would have decided if she had been given the information, which would have prevented vitiation of the reality from her. Consent is irrelevant it would be very much against the interest of justice if actions which are really based on a failure by the doctor to perform his duty adequately to inform were pleaded in trespass.” This principle has been consistently followed in later cases. Medical treatment requires the consent of a competent patient. It will be unlawful without it. As a Canadian Judge once remarked. Consent is not a mere formality ‘it is an important individual right to have a control over one’s own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed, where it will be done and by whom it will be done.’ Again the patient may withdraw a consent once given at any time whilst still competent to do so. Consent may be oral or in writing.

238  Ibid.
239  Supra n. 127
In English Law there is no general requirement that it be in writing.\textsuperscript{241} A consent form may be helpful evidentially to establish the patient’s consent. Consent may be express or implied. In implied consent the court may discover consent, where the patient’s conduct and the circumstances reasonably lead to the inference that the patient was agreeing to the procedure. It may also be held to exist where the procedure is necessarily incidental to the main operation consented to.

This for example, will be the case for anaesthesia. The Department of Health’s model consent form contains a modified version pointing out to a patient that only procedures that are ‘necessary to save my life or to prevent serious harm to my health’ will be carried out.\textsuperscript{241} It also allows the patient to indicate which procedure he would not wish to have without being consulted. A valid consent in law requires that the patient be competent,\textsuperscript{241} the consent should be real and the patient’s agreement should be voluntary and not reached as a result of undue influence.\textsuperscript{242} Consent is a state of mind of the patient stated Bristow J in \textit{Chatterton v. Gerson} \textsuperscript{243} and again in \textit{Sidaway v. Board of Governors of the Bethalem Royal Hospital}, Sir. John Donaldson MR said \textsuperscript{244} that the patient was not aware of the nature of what was being done and thus her consent was not ‘real’. Battery is an intentional tort, related closely to the crime of assault, and as a result it seen as inappropriate cause of action where the doctor has acted beneficially in the patients ‘best interest.’ There is application of necessity.

The Canadian case of \textit{Malette v. Shulman} \textsuperscript{245} represents the position in English law: any unauthorized touching is technically a battery and a Civil claim can be maintained even if there is no evidence of damage to the plaintiff. There are several rules of consent which if not abided may lead to legal liability.

\textsuperscript{241} Ibid.
\textsuperscript{241} [1984] 1 All ER 1018 at 1026. 247
\textsuperscript{242} Ibid.
\textsuperscript{243} Supra, n. 209
\textsuperscript{244} Supra, n.79
\textsuperscript{245} [1998] 67 DLR (4\textsuperscript{th}) 321
The first rule of consent obtained by fraud or misrepresentation should be treated as no consent and therefore a trespass claim should be possible. Mainly there are two kinds of consent ‘informed consent’ and ‘true consent’. In formed consent is an American concept which requires all material ‘when a reasonable person, in what the physician knows or should know to be the patients position, would be likely to attach significance to the risk.’ In England, on the other hand, the Majority of the House of Lords in Sidaway categorically ruled out “informed consent” where only Lord Scarman was prepared to adopt the translantic doctrine. The English approach is best evidence by the judgment. By analyzing the rules of evidence the main rule is explained by Bristow J in Chatterton v. Gerson. Later it is approved by the House of Lords in the nature of the proposed treatment, in turn, that will be determined by what other responsible practitioners, in similar circumstances, would have done. If the patient has been informed and thereafter gives his consent he cannot subsequently sue in trespass, although if the procedure is not properly carried out, he will be liable to sue in negligence.

The second rule of consent is that a patient who has given true consent to medical treatment cannot have that consent vetoed by another person. This rule applies with equal force whether the patient is a mature adult or a 16 year old. Those who are related to patients, whether by blood or marriage, may view this rule with some disquiet and surprise. In Gillick v. West Norfolk and Wisbech Area Health Authority House of Lords held that a mature girl under the age of 16 could seek contraceptive advice and treatment from a health carer without her parent’s knowledge and involvement, although every effort should be made by the health carer to encourage the girl to involve them. Ultimately however, the decision is that of the patient, and no one else.

Third law of consent is that a patient does not have an unfettered right to refuse treatment, but in appropriate circumstances a refusal to be treated may be ignored. Every adult has the right and capacity to decide whether or not he will

246 Supra, n.79
247 Supra, n. 209
248 Supra ,n. 183
accept medical treatment. Lord Donaldson stated that a person has a right to refuse treatment, whether that decision is founded on a rational or an irrational reason.

In three recent cases, the patient’s wishes not to be treated were not obeyed. In Re T a pregnant woman’s decision not to have a blood transfusion on religious grounds, while given careful consideration by the court, was ultimately ignored on the ground that she lacked the capacity to make the particular decision while the judge at first instance based his decision on the fact that the treatment was in the patient’s best interest.

Competency of person who is entitled to give the consent is another relevant matter. True consent can be given by a conscious, competent, adult patient voluntarily. Such a person must also be in possession of a certain amount of information relating to his treatment and it must be established that the patient has understood the information given. The competency of person who had given consent is noted as follows.

(1) be an adult, ie aged 16 or over as laid down by Family Reform Act.
(2) be competent
(3) be conscious.
(4) be in possession of a certain amount of information on which to base his decision.
(5) have understood the information provided.
(6) have given the consent voluntarily.

The fourth rule states that patient must be conscious and able to consent. If the patient is unconscious, treatment can only be administered if it is in his best interest. For the matter of scrutiny of consent, court was guided by the following guidelines.

---

249 ReT [1991] 2 Mod.L.Rew 162
250 Rew (medical treatment) [1992] 4 All ER 627.
251 Rule 2(3) of Law of Medical Liability
252 Frenchay Health Care NHS Trust v. Soni, [1981] 2 All ER 403
(1) The inability of the patient to make the decision for himself.
(2) Whether the patient had earlier expressed any choice as to his proposed treatment.
(3) The need for that particular treatment not be administered.
(4) The consequence of the treatment not be administered and
(5) The wishes of those closest to him, eg - a spouse or relative. 253

The fifth law of consent states that the patient must be in possession of a certain amount of information prior to giving true consent. At the same time the patient must have understood the information provided. 254 In the multicultural society in which we live, it would be most surprising if all patients had the same level of capacity for reading, writing or understanding the English language. The healthcarer needs only to be reasonably (not absolutely) assured that the patient has understood. This may be achieved by simply asking if he has any question or if he has understood every thing.

The seventh rule of consent is that the patient must give his consent voluntarily. As a general rule a patient’s ability to consent voluntarily to treatment is not determinable by his status at the particular time. Consequently a detained prisoner of sound mind has the same right to consent or refuse consent to treatment as a ‘free’ person and the right has to be respected by all. 255

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 expressed or it may be implied. In the case of unconscious patient if admitted to hospital, the casualty officer may argue that, although the patient was clearly unable to consent to treatment, his consent could be implied or presumed on the ground that if he were conscious he would probably consent to

---

253 The use of a legal fiction of this sort was disapproved of in Marshall v.Curry , [1933] 3 DLR 260 at 275.
254 Rule 2(H) of Law of Medical Liability
the saving of his life in this way. Although this may be true and although the majority of the patient could be expected to endorse the decision to treat in such circumstances, it is rather fictitious way of approaching the problem. The principle of non-consensual medical treatment would be limited to the patient such that could not be applied when the patient is unconscious and object to the treatment: the value of the individual’s control over his own body would be held to outweigh the value of enhancing his state of health or indeed of saving his life.

Again the basic negligence theory is also based on the promise that: “each man is considered to be the master of his own body” The courts however have been unwilling to declare that a patient’s autonomy is absolute, particularly in cases involving consent to treatment considered to be dangerous or refusal of consent to life-sustaining treatment. A competent patient’s decision to accept or refuse care sometimes has been overridden when it has come into conflict with the state’s interest in the preservation of life, the protection of third parties, prevention of suicide, to maintain the ethical integrity of the medical profession or to safeguard the public health. In Jacobson v. Massachusetts the United States Supreme Court upheld a State law requiring smallpox vaccination regardless of the patient’s consent. In rejecting Jacobson’s contention that the procedure was an unauthorized invasion of bodily integrity the court held that compulsory vaccination was within the State’s police power because the unvaccinated posed threat to the well-being of the humanity. In Canterbury v. Spence a case on informed consent, asserted the general proposition that “in the absence of emergency, the physician must obtain the necessary authority from relatives before administering treatment to a incapacitated patient.” In at least eight states of America this rule is embodied in a statute establishing consent. The Mississippi Statute which is the most comprehensive, enumerates seven categories of relatives who may provide substituted consent for a patient, under specified condition. In the event of a

256. Supra, n. 158
257. Ibid
258 197 U. S 11.49 L.Ed. 643.1905
259 Supra n. 158
260 Ibid.
disagreement among the family members, the consent of any one relative is enough to permit the physician to proceed with treatment. 261

In most States ‘there is no statute designating who can give consent for the incapacitated patient. Instead, doctors and hospital have been left to interpret a handful of indefinite and conflicting common law precedents. The rule in Kentucky, for instance, is that in surgical cases consent must be obtained “from a near relative capable of giving consent”’ 262 In Kansas the law is even more vague” if the patient is incompetent the consent must be obtained from someone legally authorized to give it for him. 263

It goes without saying that a conscious adult patient of sound mind is entitled to decide for himself whether or not he will submit to a particular course of treatment proposed by the doctor. This entitlement is the foundation of the doctrine of informed consent, which originated in United States of America 264 and found favour by the Supreme Court of Canada. 265 The North American concept of Informed consent implies an objective test of a doctor’s duty to advise the patient of the advantage and disadvantages of undergoing the treatment proposed and more particularly to advise the patient of the risks involved.

According to the majority decision of the House of Lord’s in Sidway 266 the English law does not recognize the doctrine of informed consent. The test of liability in respect of a doctor’s duty to warn his patient of risks inherent in the treatment recommended by him is the same as the test applicable to diagnosis and treatment, namely that the doctor is required to act in accordance with a practice accepted at the time as proper by a responsible body of medical opinion.

262 Ibid
263 Ibid
264 Supra, n.190.
266 Supra, n.79.
A medical practitioner—physician or surgeon will leave no stone unturned to inform his patient of the advantage and disadvantages, the risks and benefits of any proposed course of treatment, so that the patient may exercise his right to self determination about the proposed course of treatment including investigation performed for the purpose of routine screening or for the specific purpose of different diagnosis. When questioned specifically by a patient of apparently sound mind about the risks involved in a particular treatment proposed, the doctor’s duty is to answer both truthfully and as fully as the questioner requires. The question of disclosure of risks tested by the tenets of “accepted professional practice” may vary from patient to patient depending on the needs of the particular patient. The obligation to disclose risk of electric medical procedures such as sterilization operation or cosmetic surgery depends on the principle of accepted professional practice. Where the doctor had carried out his duty to inform the patient of the implication of the operation, he was not liable for failure to warn the patient of the possibility of loss of muscle power in the leg of the patient, which was not foreseeable risk of operation.

The majority of the House of Lords did not hold the surgeon negligent for failure to warn of the risks of damage to the spinal cord of the patient, because the surgeon’s non-disclosure of the risk of damage to the patient spinal Cord accorded with a practice accepted as proper by the responsible body of neuro-surgical opinion.

The criteria for informed consent with regard to abortion of a pregnant woman laid down in Pennsylvania abortion legislation was upheld as constitutionally valid by the United States Supreme Court by holding “that except in a medical emergency (i) at least 24 hours before performing an abortion, a physician must inform the woman of the nature of the abortion procedure, the health risk of the abortion and of child birth, and the probable gestational age of the unborn child (ii) the physician or a qualified non-physician must inform the women of the availability of printed material published by the State describing the foetus

267 Supra, n.79.
268 Supra, n. 191
269 Supra, n. 254
270 Supra, n. .79
271 Supra, n. 65
and providing information about medical assistance for child birth, information about child support from father, and a list of agencies which provide adoption and other services as alternatives to abortion and (iii) the woman must clarify in writing that she has been informed of the availability of these materials.”

In India, in the Ram Bihari Lal’s case,\(^2\) the surgeon did not explain the hazards of chloroform anesthesia before taking consent of the patient for operation of appendicitis. On finding appendix to be normal he proceeded to remove the gall-bladder without consent and without caring for the ill-effects of keeping the patient under chloroform especially when her kidneys were affected. Accordingly, the surgeon was held liable for negligence. Another relevant aspect is law relating to the validity of consent.

### e Validity of Consent

Consent generally is in the form of written consent. Several organisations as well as large number of commentators have recommended the use of written directive, or “living wills”\(^3\) as a possible means. In this way, a competent adult may continue to control medical decision making, in the event he subsequently becomes incapacitated. The next relevant area is in discussing as to what needs to be disclosed for the purpose of consent.

### f What is the Need for Disclosure

Most disputed area relating to consent is the non-disclosure of the risk involved in a particular treatment. A person should not be exposed to a risk of damage unless he has agreed to the risk. The court has been of some assistance in assessing what risks are materials. These have been defined as those risks which are reasonably probable and which must be considered to be fairly serious in their

\(^2\) AIR 1982 M.P. 132.

\(^3\) Per Wood house J (1964) 2 NZLR at p. 250
effect. In the United States, there are some jurisdictions in which the full disclosure rule applies and others in which the professional standard has been accepted. Within the Common Wealth there is decision ranging from the endorsement of the deliberate medical lie to the acceptance of the extreme patient–oriented approach, which emphasizes complete disclosure of risk. The diversity of opinion is equally evident in academic discussion. Some writers have thought to give the informed consent doctrine extensive scope while others have urged caution in the fact of what has been seen as a indirect or inappropriate means of widening the potential liability of doctors.

The three most significant cases for British Courts are Bolam v. Friern Hospital Management Committee, Smith v. Auckland Hospital Board and Chatterton v. Gerson. Bolam concerned the administration of electro-convulsive therapy –without an anaesthetic as was common at that time to a mentally ill patient, to whom, the risk of fracture in such a procedure has not been explained. The court expressed the view that the doctor was entitled to proceed without explanation of the risks in the light of the patient’s condition.

In another case Smith v. Auckland Hospital Board, the patient alleged that he did not give his informed consent to the performance of an auto gram as he was not told of the risk it involved. In a dictum, which has, since been widely referred to, the judge outlined what should be taken into account in deciding what the patient should be told. The paramount consideration is the welfare of the patient and good faith on the part of the doctor. It depends upon the patient’s overall needs. What is to be taken into account should be the gravity of the condition to be treated, the importance of the benefits to be expected to flow from the treatment or procedure, the need to encourage the patient to accept it, the relevant significance of

274 Supra, n.79
275 Supra, n. 143
276 (1964) NZLR, Vol.3, at p. 250
277 Supra, n. 209
278 [1964] NZLR. Vol.3. p.250
its inherent risks, the intellectual and emotional capacity of the patient to accept the information without such distortion as to prevent any rational decision at all. And the extent to which the patient may seem to have placed himself in his doctor’s hands with the invitation that the latter accept on his behalf for intricate or technical decisions. 279

A physician’s conduct must always maintain the standard of care set by the profession, or they may be liable for malpractice. Physician and surgeon must possess and exercise the same kind of skill and learning ordinarily possessed and exercised by other members of their profession under similar circumstance. Informed consent is something which needs more explanation. Another relevant area related to law of consent is refusal of treatment-consent to.

g. Refusal of Treatment –Consent to

The patient has a right to control his own body. The tort of battery protects the interest in bodily security from unwanted physical interference. Any non-conscientious touch which is harmful or offensive to a person’s reasonable sense of dignity is actionable. A competent adult is entitled to reject a specific treatment or all treatment to select an alternative from of treatment even if the decision may entail risks as serious as death and may appear be a mistake in the eye of the medical profession or of the community. The doctor cannot disregard a patient’s advice or instructions, though in an emergency the doctrine of necessity may protect the physician who acts without consent. The interest of the State in protecting and preserving the lives and health of its citizens may override the individua’sl right to self- determination in order to eliminate a health threat to the community, but it does not prevent a competent adult from refusing life- preserving medical treatment. 280

279 Per Wood house (1964) NZLR at 250

Consent is implicit in the case of a patient who submits to the doctor and the person alleging it must make out the absence of consent.\textsuperscript{281} When a surgeon or medical man advanced a plea that the patient did not give his consent for the surgery or the course of treatment advised by him, the burden is on him to prove that the non-performance of the surgery or the non-administration of the surgery or the non-administration of the treatment was on account of the refusal of the patient to give consent there to.\textsuperscript{282}

In \textit{Navy Beth Cruzan’s case},\textsuperscript{283} Missouri trial court directed the Hospital authority to cause the parent’s request to be carried out. On appeal, the Supreme Court of Missouri reversed the decision of the trial court by holding (i) that although the woman was in “Persistent vegetative state”, she was neither dead, nor terminally ill, (ii) that the woman’s right to refuse treatment whether such right proceeded from a constitutional right of privacy or a common law right to refuse treatment- did not out weigh Missouri’s strong policy favoring the preservation of life, (iii) that the women’s conversation with her house maid was unreliable for the purpose of determining her intent and thus insufficient to support the patient’s claim to exercise substitute judgments on the woman’s behalf, and that (iv) no person could assume the choice of terminating medical treatment for an incompetent person in the absence of clear, convincing and inherently reliable evidence, which was absent in the case at hand. The US Supreme Court confirmed the decision of the Supreme Court of Missouri. The Court of Family Division held that\textsuperscript{284} in view of the critical condition of the premature baby and lack of suitable synthetic alternative to blood products, it was appropriate to override parental objection and authorize blood transfusion, for the survival of the premature baby. Lord DONALDSON\textsuperscript{285} gave guidance to the hospital authorities and to the medical profession in situations involving a refusal to consent to treatment in the following way.

\begin{thebibliography}{9}
\bibitem{281} T.T. Thomas v Elisa AIR 1987 Ker 52
\bibitem{282} Airedale NHS Trust v. Bland, [1993] 1 All ER 812.
\bibitem{283} Nancy Beth Cruzan v. Director, Missouri Department of Health, (1990) 497 U S R.261
\bibitem{285} [1981] 120 DLR (3\textsuperscript{rd}) 269
\end{thebibliography}
“A patient’s interest consists of his right to self-determination. Society’s interest is in upholding the concepts that human life is sacred and should be preserved if possible. In a situation where these two interests conflict, the right of the individual is paramount. But where there is doubt, the doubt has to be resolved in favour of the preservation of life.” Thus there are legal complications relating to consent and disclosure of information. Law relating to consent is also linked to the right to privacy. Another important aspect is law relating to Medical Information and Confidentiality and a Child’s right to privacy. It can be considered as a relevant factor of medical liability.

T. Medical Information and Confidentiality Linked to Child’s Right to Privacy

Medical information and its confidentiality is the most important aspect of liability under the theory of medical jurisprudence. Specialists are held to keep the standard of care of other specialists in the same field under similar circumstance. The specialists, because of their advanced training and knowledge, are held to a higher standard than that required of general practitioners. Even though not certified as a specialist, those who hold themselves out to be specialists or perform procedures normally done by specialists will be held to a specialist’s standard.

Under the European Convention on Human Rights, Children have a right to privacy and such a right has begun to be acknowledged in UK Law. It is therefore unlikely that the law would develop further so as to deny an infant’s interest in privacy, including that interest has been invaded by unauthorized disclosure. However, it may illustrate that the courts might be reluctant to find detriment when there has been no injury to feeling or other material adverse outcome.

286 Art 8 of United Nations Convention on the Rights of the Child, 1989 (State parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference)
It might be argued that if disclosure promotes the child’s overall welfare as for example, where disclosure results in the parental consent to treatment, the child suffers no detriment. Even setting aside the question of whether an invasion of privacy has occurred and is a detriment, in relation to older children, this overlooks the injury done to the children's sensibilities where disclosure occurs against the child's wishes. Lord Keith of Kinkel considered that even where the information disclosed showed the confident in a favorable light, in fact that disclosure took place against the wishes of that individual and would be a sufficient detriment.\textsuperscript{287} It is suggested, therefore, that this argument is more inappropriate and raised in the context of whether a disclosure can be justified rather than whether a detriment has been suffered.

In relation to children, when the parents bring a baby to a doctor, the purpose of the visit is to obtain treatment for the child. It enables the parents to obtain advice concerning what the baby requires in order to attend to the welfare of their child and to consent to any necessary treatment. When the doctor obtains information about the child in the course of such a consultation, the disclosure to the parents can be said to be authorized, that it is disclosure to fulfill the purpose for which it was imparted, usually to obtain parental consent to treatment.

The development of law of confidentiality to protect Article 8 Right has resulted in a stronger basis for a child’s claim to protection by an action for breach of confidence.\textsuperscript{288} The tension between the welfare interest and the autonomy rights of the child, which is a recurring feature of child laws, is also likely to form part of the law of confidentiality when applied to children. This is the development of law relating to medical information confidentiality and a child’s right to privacy. The next concept is the medical practice relating to AIDS patient.

\textsuperscript{287} \textit{Ibid.}
\textsuperscript{288} Supra n.286
a HIV AIDS And Medical Practices

An estimated 40 millions people worldwide are living with HIV/AID of which 37 million adult and 2.5 million are children younger than 15 years of age. Approximately two thirds of these individuals live in sub-Saharan Africa and another 18 percent or 7.4 million live in Asia and the Pacific. An estimated 5 million new HIV infection occurred worldwide during 2003. More than 95 percent of these new infections occurred in developing countries, and nearly 50 percent were females. In 2008 AIV/AIDS related disease caused-death of approximately 3 million people world wide, including an estimated 500,000 children younger than 15 years of age. The CPC estimate that 850,000 to 950,000 American are current HIV positive a quarter of whom are unaware of their infection. It is estimated that over 380,000/- people are living with AIDS, with about 40,000 new infections occurring each year. The legal environment surrounding HIV and AIDS is still developing. An HIV case involves application of the traditional tort concept of duty, breach and causation. In order to establish liability, the plaintiff must prove that the “defendant’s conduct was negligent and proximately caused plaintiff injuries.” Determining whether the defendant is negligent, or not caused a defendant to owe to a duty of care to the plaintiff which is analyzed in terms of foreseeability. This is the position of law relating to AIDS patient in malpractice cases. Another most relevant area is the negligence of medical practitioner, which forms the main legal component of medical liability under the title of medical negligence. Medical negligence may be classified as (1) Negligence of the Medical practitioner (ii) Negligence of nurse and staff (iii) Negligence of the hospital authority. Negligence of medical practitioner is the most important aspect of medical negligence.

290. Ibid.
291. Ibid.
293. Ibid
U Negligence of Medical Practitioner

A person who holds himself out ready to give medical advice or treatment impliedly undertakes that he is equipped with skill and knowledge for the purpose. Such a person whether he be registered practitioner or not, and who is consulted by a patient owes him certain duties viz.

(a) a duty of care whether to undertake the case.
(b) Duty of care as to what treatment to give.
(c) A duty of care in administration of his duties.

A breach of any duty mentioned above will support an action for negligence by the patient. A medical practitioner who examines a person against his will and without statutory authority to do so commits a trespass. A surgeon who performs an operation or part of operation without the patient’s express or implied consent is guilty of trespass. Liability for medical negligence is something more relevant. The following are the legal burden created by law due to medical liability.

a. Liability for Negligence

American Experience

The tort system of liability for negligence has two main purposes. First, it provides compensation to those injured as a result of the negligence of others, thereby acting as a source of insurance. Second, by imposing sanction on the person who is found negligent.

The first case in America was in 1794 in *Cross v. Geithery.* A leading New York case *Pike v. Hosinger,* observed that the doctor was not liable for an error of judgment, provided he does what he thinks in the best after careful examination. He has an implied engagement with his patient regardless of whether

295 U.S.R 1990 Vol.61
296 49 N.E.760 (1898), 155 NY 201 (1898)
certain representation had been made. Patient is not guaranteed a good result, but he promises by implication to use the skill and learning of the average physician to exercise reasonable care and exert his best judgment in the effort to bring about a good result. 297

The courts in USA have laid down four elements to establish claims for malpractice. 298

First-the patient must prove that a doctor-patient relationship has been created. By creating this relationship, the physician is said to have assured a duty of reasonable care of the patient

Second-the physician must not breach the duty of non-negligent care to the patient. The breaching of failure to exercise the requisite duty of care is a relative act. eg: a mistake in diagnosis or miscalculation in a test report is not necessarily automatic evidence of legally recognized act of negligence. Jurisdiction uniformly applies some general standard relating to the reasonableness of the act with regard to similar practitioners in a similar situation, to judge the liability of a physician’s act. In other words, if the duty of care exercised by a physician is determined to be unreasonable as compared to other physician of similar training and practice, then the physician is said to have breached the duty of care owed to the patient.

Third- not all acts of negligence or instance where the duty of care is breached will make a physician liable for malpractice unless the patient suffers some harm. The harm can be physical, or emotional, Psychic damage for example are result of physician exploiting a patient for sexual purpose. It is not necessary in proving injury that the impact or damage to the patient was deviating or chronically


298 Supra, n .294
deliberating. However the greater the extent of injury, the greater the potential for successful litigation as well as the possibility of a large compensating award if the cause of action is upheld.

The last element, proximate cause is often confusing and difficult to prove. Mere evidence of a negligent act committed by a physician with a duty to care for a patient who suffered a significant harm will not necessarily be sufficient to maintain a course of action for malpractice. Thus there must be a causal link between the negligent act and the patient’s injury for an action in malpractice to be sustained. The presence of every intervening agent or event that tends to intervene between the negligent act and injury is said to sever the causal relationship.\textsuperscript{299}

In brief an action for malpractice must include evidence of all elements,

\begin{enumerate}
  \item duty.
  \item breach of duty.
  \item harm to patient and
  \item proximate cause, in order to be successful . Any omission or failure to prove one of these factors will defeat the action.
\end{enumerate}

These are the main developments of law in this area. In this context obligation of the doctors is to be considered for fixing liability upon them.

\textbf{b. Obligation of Doctor}

The obligation of doctor is explained as follows:\textsuperscript{300}

\begin{enumerate}
  \item At the very outset it should be borne in mind that “the physician is in a position of trust and confidence as regard his patient, and it is his duty to act with the at most good faith towards the patient. If he
\end{enumerate}

\textsuperscript{299} \textit{Ibid.}

\textsuperscript{300} \textit{Hamunond v. Actna Gas and Sur Co} 237 F Supp; 96 (1965).
knows that he cannot accomplish a cure, or that the treatment adopted will probably be of no benefit, it is his duty to advice his patient of these facts.\textsuperscript{301}

(2) “The facts that a physician or surgeon renders service gratuitously does not affect his duty to exercise reasonable and ordinary care, with skill and diligence.\textsuperscript{302}

(3) “It is one of the fundamental duties of a physician to make a proper skillful and careful diagnosis. If he makes an incorrect diagnosis, he may be liable to that patient. Further the doctor must ‘inform himself by the proper tests and examination of the condition of his patient to undergo a proposed treatment or operation, so that he may intelligently exercise the skill of his calling.\textsuperscript{303}

(4) The duty of exercising reasonable skill and diligence “includes not only the diagnosis” and treatment, but also the giving of proper instructions to his patient in relation to conduct, exercise and the use of an injured limb.\textsuperscript{304}

(5) A physician cannot fail to give a patient proper after care treatment or abandon him without risking legal responsibility for any ill effects.\textsuperscript{305} The doctor is under a duty to give the patient all necessary care as long as he requires attention, and the unwanted lack of diligence in attending the patient renders the physician liable

\textsuperscript{301} Habas \textit{v.} Pittman 118 Aniz 305 576 p.2d 493 (1975)
\textsuperscript{303} Ibid
\textsuperscript{304} (1898) 155 N.Y.R.2001
\textsuperscript{305} A.M.A, \textit{Principle of Medical Ethics}, Sec.5 (1979);Q Neil \textit{v.} Montefiore Hoop 202.N.Y.R.7
for malpractice. As early as 1891, the court said that when a physician engages to attend a patient without limitation of time he cannot cancel his visit except, first with the consent of the patient, or secondly, upon giving the patient timely notice so that he may employ another doctor, or thirdly, when the condition of the patient in such that he no longer, requires medical treatment, and of that condition the physician must judge on his part.

(6) The complaints, observations and demonstration of a patient must be heeded by the physician to a reasonable extent.

(7) Informed consent: A doctor may be liable for malpractice if, in rendering treatment to which the plaintiff consents, he fails to make a frank disclosure to plaintiff of the risk involved in the procedure. In Natanson v. Kline it was held that the jury should find an informed consent given by the patient for such treatment, the jury should next determine whether proper skill was used in administering the treatment.

So the development of law relating to liability for negligence and the legal obligation of doctors concludes here. The next relevant aspect of medical negligence is the vicarious liability of hospital authorities and doctors.

c Vicarious Liability

The law relating to vicarious liability is the most important part of medical negligence liability. If the doctor is an employee of hospital then the hospital is vicariously liable. The hospital is independently liable only if it is

307 Ibid.
308 186 Kan 393 (1960) : 350 P.2d.1093
negligent in its administration or housekeeping functions, for example causing a patient to slip and fall on a wet floor, but was otherwise immune from liability.\textsuperscript{309}

In contemporary tort law, negligence liability is generally considered as the general rule and strict liability is the exception. In medical profession, the physicians have been traditionally treated as independent contractor rather than an employee, relieving the hospital of vicarious liability for their negligent acts.\textsuperscript{310}

In recent Texas case, \textit{Berd v HCA Health Service of Texas Inc} \textsuperscript{311} court held that doctor’s function is considered to be an inherent part of the functioning of the health care institution and the court have held that the institution cannot escape liability of the physician. Vicarious liability applies in spite of a physician’s independent contractor status.

Courts often impose liability on the institution for the errors of its health care based on either the corporate negligence or vicarious liability doctrine. The principles of vicarious liability have been extended to health care organization such as Hospital authority, courts using the “control” test of agency to analyze the status of physician in the hospital authority. Vicarious liability creates more responsibility over the hospital authority, and this encourages them to select physician with the best credentials. Otherwise the profit motive may tempt the authorities to retain physician with the least credentials for the lowest prices.


\textsuperscript{310} All ER (1991) 7.p.671.

\textsuperscript{311} No. 01-93. 00513.C.V, 1994 W L 69943 Tex.ct,App. Mar.10,199
The doctrine of corporate negligence is a recently emerged doctrine. In Thompson v. Nason Hospital the court found that corporate negligence theory advanced against hospital for the adverse effect of treatment or surgery was approved by physicians who were not hospital employees. To prove this failure of the hospital to supervise the quality of care or competence of its staff, the plaintiff must prove that the hospital had actual or constructive knowledge of the procedure used and that the hospital’s negligence was a substantial factor in the bad outcome. Other courts also held that hospitals are responsible for failure to review and monitor the medical service provided. Negligence of the Hospital Authority is the main component of vicarious liability. Vicarious liability of the hospital authority is the main aspect of law to be examined in detail.

d. Negligence of the Hospital Authority

The negligence of the Hospital Authority is the most important area of vicarious liability. The governing body of hospital is liable for the acts of the servants or agents but a medical practitioner does not give medical treatment as servants or agents as the authority has no order and control over the mode of doing treatment. So the authority is not liable for wrong treatment, if due care and skill are exercised in the selection has been decided in the case Harne v. Fisher.

In another case the hospital authority was held liable for the negligence of the members of the staff irrespective of such staff whether employed by the authority are under contract of service or not. In all the above situations the liability to the person injured depends upon the failure to exercise the amount of care as a man of prudence would have taken in the situation. Liability of Hospital staff is also under the perview of vicarious liability. The following are the liability of hospital authority under the doctrine of respondent superior.

312. 1927 AC 573
313. 1969 AC 132
e Respondent Superior

Respondent superior is the main principle of tort law and is applicable in medical offence. Generally hospital, as charitable institution was offered absolute immunity from tort liability. Aside from charitable considerations, the court also rejected hospital liability based on traditional principles of respondent superior since the staff (physician, nurses and other skilled professionals) was considered akin to independent contractors. As such, they perform patient care function with the level of skill required for their profession. As a result the hospital, being unable to control these professionals or dictate the course of the treatment provided, could not be held liable for its employee’s negligence.

In the New York case of Scholendroff v. Society of N.Y. Hospital 315 the court held that hospital liability for the negligence of its employees depends on whether the causative act of injury was ‘administrative” or “medical”. Administrative acts are considered to be those in the realm of hospital control; whereas medical acts were not. This naturally gave rise to many inconsistencies in interpretation of what exactly constituted medical or administrative tasks. Notwithstanding the difficulties in interpretation, the basic issue was whether or not the hospital could have any control over the particular act involved.

The nature and public perception of the hospital institutions has changed, liability of the hospital for the negligent act of its staff has emerged as a viable claim. As the court in Scholenldorff explained “hospital has evolved into highly sophisticated corporation operating primarily on service basis. The corporate hospital of today has assumed the role of a comprehensive health center with responsibility for arranging and coordinating the total health care of its patients.” Today, what the public expects of a hospital is providing provision of facility with responsibility for all aspects of patient care.

According to decision by the *New York Court in Bing v Thunig*, hospital,\(^{316}\) are no longer exempt from rule of liability based on respondent superior. A woman was burned during an operation as a result of surgeon’s use of electrocautery. The bed linen ignited during the operation contaminated by a zephiren solution when the nurse was preparing the patient for surgery. The court held that both the surgeon and hospital are liable jointly. The court allowed recovery against both, holding that the hospital should bear the same burden as other employees, including responsibility for negligent acts of its employees committed within the scope of their employment. Another aspect that is important in this context is the corporate liability of hospital authority.

**f. Liability for Corporate Negligence of Hospital Authority**

**Corporate Negligence Doctrine**

Corporate liability of hospital authority is the most developing area in twenty-first century. For the greater part of a century “the doctrine of charitable immunity released hospital from accounting for tort liability.” Public policy affirming the hospital role as a non-profit charity, however, grew outdated as hospitals developed into sophisticated businesses. Court eventually rejected this doctrine, favouring instead the doctrine of respondent superior.\(^{317}\) The action against the hospital was based upon theories of respondent superior, ostensible agency and the hospital’s independent act of negligence.\(^{318}\)

The theory of cooperate negligence, as originally introduced in 1964, has expanded hospital liability for the medical care and patients services provided by physician or other, including employees and independent contractors. Pursuant to the theory the hospital is charged with certain responsibilities that are owed directly to the patient regarding service provided within the facility.

\(^{316}\) N.Y.R.(1987), Vol. 5 at p. 894

\(^{317}\) *Gable v. Salvation Army*, 100 2d 244 *Oklama Law Review* 1940.

\(^{318}\) *Sibharat v. Perry Memorial Hospital Training* All ER 1990 Vol.7 p.638.
The leading case that established the theory of corporate negligence is *Darling v. Charleston Community Memorial Hospital* \(^{319}\) the plaintiff brought an action directly against the hospital where he was originally treated. The patient alleged that the professional competency of the medical and nursing staff was the responsibility of the hospital. In *Darling*, the hospital failed to appoint sufficient trained nurses to recognize the gangrenous condition of the leg. Further, the hospital failed to require consultation or review of the treatment rendered by the on-call emergency room physician. According to the court, either of these grounds would support the jury’s verdict that the hospital was negligent.

Again in *Thompson v. Nason Hospital* \(^{320}\) it was held that duties of the hospital can be divided into four areas. These are (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipments (2) a duty to select and retain only competent physician (3) a duty to oversee all persons who practice medicine or engage in patient care (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for all patients.

In *Purall v. Zinbelman*, \(^{321}\) the plaintiff brought a malpractice action against a physician treating his conditions, and against the hospital for granting staff privileges to a physician whom it should have known was not competent. Court held that, the hospital owes certain duties directly to a patient, which is defined as non-delegable by licensing, regulations, accreditation standards and hospital by laws. In an accredited facility, the governing body (ie the bound of trustee) has ultimate responsibility for the quality of patient care. In this case court held that if the hospital assigns review or supervision of the physician to a particular

---

\(^{319}\) All ER 1965- Darling involved a boy with multiple leg fracture who was heated by an on call emergency room physician. The physician applied a plaster cast and admitted the patient to the hospital but the physician never consulted an orthopedist to review his treatment. Within 7 days the nurses observed that the patient’s toes became dark in colour, swollen and a strong odor was emitted from the cast. Although adjustments were made in the cast by the same physician 7th conclusion of the leg worsened. When the patient was finally transferred to another hospital, the leg had become gangrenous and ultimately had to be amputated eight inches below the knee.

\(^{320}\) 527 p.330, 591, A 2d, 703( 1991)

\(^{321}\) All ER (1972) 8 p.112.
department and such assignment does not release the hospital from direct responsibility and liability for negligence. The court held that “the department of surgery was acting for and on behalf of the hospital in fulfilling this duty and if the department was negligent in not taking any action against patient or recommending to the board of trustee that action would be taken, then the hospital would also be negligent.

According to the court, it was customary for the hospital to review, through committee, the practice of staff physician and to restrict or suspend those who do not demonstrate competency in a particular area. Again, this duty is non delegable and ultimately remains the responsibility of the hospital.

In order that the hospital may become liable under a theory of corporate negligence, there must be evidence that it had actual or construction notice of the defect or process, which created the harm. To establish liability on the part of a hospital, causation must also be proved. The plaintiff must prove that negligence of the hospital was ‘substantial’ in causing the injury. The theory of corporate negligence imposes liability on a hospital for failing to select and retain only competent physicians. Corporate liability of hospital is a new emerging area. So a detailed explanation is provided in the next chapter under the topic of consumer liability of hospital authority.

g. Liability of the Nurses

A nurse, like any other person, is liable for negligence in the performance of her duties, provided that, skill and care are used in selecting duly qualified nurses. In the case of Strengways Lesmere v. Dayten 322 the plaintiff’s wife lost her leg owing to an over dose of dangerous drug administered just before the operation by two nurses in the hospital. The over dose was due to the mistake on the part of nurse is reading the amount ordered by the doctor to be administered. The nurses were guilty of negligence and were held liable.

322 (1936) 2 KB 11
In India, the Nursing Council Act was passed in 1947. In U.K. Nursing Council Act was revised in 1949. A person belonging to skilled and learned profession may become liable to pay damages for harm caused by his negligence. The legislation focused on recognition of qualification and disciplinary proceeding for misconduct.

Halsbury tells us that the general principles set out above are applicable not only to physician and surgeon, but also to dentists, veterinary surgeon, nurses and midwives and all others who give medical advice or treatment.

1. A nurse is personally liable for negligence in the performance of her duties.

2. A hospital authority or nursing home is responsible (besides the nurse herself) for negligence of nurses employed by the hospital authority, nursing home where the negligence arises in the course of her employment.

3. Where an association or body of persons supplies the nurses to hospital etc. Then the liability rests on the association.

4. A nurse will not normally be guilty of negligence, if the acts or omission complained of as negligence, was actually a faithful and careful compliance with the order of a surgeon, physician or anesthetic concerned. 323

In case of a nurse, the main defence is that she was acting in accordance with acceptable professional practice, and therefore not negligent, not that she was doing what she was told. In Gold v. Essex, Goddard L.J 324 examines the nature of the nurse’s duty. He argued that ‘if the surgeon gives a direction to the nurse, which she carries out, she is not guilty of negligence, even if the direction is improper’.

323  Gold v. Gold [1942] All ER
324  Ibid.
In England there are many medical controls over nurses and midwives. There is strictly limited exception to this monopoly for midwives and occupational health nurses. So the prescribed drugs can be said to recognize the professional expertise of doctors but not that of nurses, who may only practice their art under medical control.

h. Liability of Pharmacists

The liability of Pharmacists will come under the area of vicarious liability. In *Dayer v. Roderick* 325 established that the responsibility of the pharmacists was independent of that of the doctor, and not derived from it. Thus the position of chemists is limited to the lesser role of dispensing drugs as prescribed by doctors. It is recognized as separate, autonomous field. The law has recognised that pharmacy has legitimate control over its sphere of practice, although it remains under a degree of medical dominance because of the need for a prescription. Nursing lacks even this control. In Turner’s terminology, dominance over pharmacy takes the form of limitation, but nursing is subordinate to medical supervision. So liability of pharmacist constituted the relevant portion of medical liability. The ‘Captain of the Ship Doctrine in England’ is the most important theory relating to vicariously liability.

i. The ‘Captain of the Ship’ doctrine in England

The ‘captain of the ship’ doctrine raises the relationship between doctors and nurses in a particularly acute form. This principle is a means of making one person (the ‘captain’) responsible for all mishaps occurring under his or her jurisdiction. If the health care team can be conceived as a ship then the doctor is properly said to be its captain, and the nurses are defined as subordinate for whose actions the doctors are responsible. In brief the doctrine fixes liability for mistakes

325. [1942] 2 All ER 237.
on those with overall responsibility irrespective of their personal role in causing them. The captain is vicariously liable for their mistakes.

In *Mahon v. Osborne*, 326 a swab that had been left inside the body of patient, caused his death. The court was required to consider whether the surgeon could escape liability by arguing that the fault lay with the nurse. Sottl J. ‘accepted there was a risk of the clip becoming detached from the swab and that this risk was wholly external to the surgeon who can neither control it nor know it’. Even though the surgeon could not excuse himself from bearing this risk by relying on the nurse. He had a personal responsibility to check sewing up on the incision. According to “captain of the ship” theory he is responsible in all aspects of the operation. It requires doctors to check personally that no foreign body is left before closing the wound. But this does not make them liable for the nurses mistake as it makes them responsible for their own. So this is explained as ‘Captain of the Ship’ doctrine in England. Another relevant area is causation and damage.

**V. Causation and Damage**

Questions of causation also require the courts to make value of judgments about the ascription of legal responsibility for damage. Where damage results from multiple causes the courts often resort to the test of ‘but-for-cause’. That is, would the loss have been incurred but for the defendant’s negligence? This notion is based on the view that the defendant should be liable only to the extent of his personal responsibility for the loss in question. If a hospital negligently fails to diagnose and treat a patient’s condition, following which he dies, the hospital will escape from liability if it can show that the patient’s condition was untreatable and that he would have died from it no matter how much care had been taken. There are cases in which the ‘but-for-test’ tends to break down. In particular where the courts have difficulty distinguishing the causal

326. [1957] 2 All ER 118.
responsibility of multiple tortfeasors, the test cannot be mechanically applied, as a matter of logic, to every instance. 327

A fundamental question in determining the outer limit of the scope of the torts of negligence is that of what the damage is or could be recognized as constituting the minimum for an actionable claim. The concept of duty of care is the meaning of fair, just and reasonable duty imposed on one party for the benefit of the other. The meaning of fairness and reasonability was reexamined in Hedley Byrne v Heller. 328 However, ‘a duty of care was denied on the ‘fair’ just and reasonable ‘ground’, with Lord Steyn taking the lead in suggesting the consideration of ‘distributive justice’ or ‘the just distribution of losses and benefits among the members of a society.’

Another relevant area relating to physical harm was considered in Mac Farlane v Tayside Health Board. 329 The majority of the House of Lords held that a woman who becomes pregnant unexpectedly following the failure of a vasectomy operation should succeed in claim for pain and suffering arising from the birth. The focus of discussion was on whether the claim should be ruled out, as the minority thought, on policy grounds, utilizing the ‘fair, just and reasonable’ head. However, an important dimension of the decision was the implicit ruling that the claimant had suffered physical damage. While it is undeniably the case that she endured physical inconvenience and pain during the pregnancy and birth, physical autonomy could be said to have been compromised by the unwanted pregnancy which it was the purpose of her husband’s vasectomy to prevent, it is not so clear that the pregnancy and birth could be described as ‘damage’ in the normal sense of injury to the person. This is not to say that the decision was wrong. As Christian Witting argues, Mac Farlane is one of a number of cases in which the courts have ‘shifted attention away from the examination of actual changes in physical structure or status of person and property and towards a more context –specific enquiry into social perception of damage. 330

328 [1939] 1 All ER 535
329 [2000] 2 AC.59
Another area is psychiatric injury and illness. The Courts accepted psychiatric injury or ‘nervous shock’ could constitute a head of damage for the torts of negligence providing compensation, in particular, where it was caused by harm or the threat of harm to a person other than the claimant. In *Frogatt v. Chesterfield and North Derbyshire Royal Hospital NHS Trust* damages were awarded to the husband and son of the woman who was misdiagnosed as suffering from breast cancer, and who had a mastectomy as a result. The husband suffered what the court referred to as ‘Sudden trauma’ when seeing his wife immediately after the operation. The son likewise suffered post-traumatic stress disorder on being told by his mother of the (false) diagnosis. The court awarded damages. In the light of this decision it is all the more strange that, psychiatric illness caused in other ways, such as by the experience of having to cope with the deprivation consequent upon the death of a loved one, attracts no damage.

In England law of torts analyse the question of causation in two stages. The first, which sometimes referred to as ‘factual causation’ ‘cause in fact’ or ‘but-for-cause’, is essentially concerned with whether the defendant’s fault was a necessary condition to the loss occurring. At this second stage the courts make an assessment of whether the link between the conduct and the ensuing loss was sufficiently close. To put it differently, judges has decide which of the conditions of the claimant’s harm and the ensuing loss was sufficiently close. The claimant’s harm should also be regarded in a legal sense to be its causes. Judges ask whether a particular act ‘broke’ the chain of causation, such as ‘direct’, ‘proximate’, foreseeable, ‘or (alternatively) ‘remote’ to describe the relation between an act or omission and its consequence. A but for-cause which does not pass one of these tests of (legally relevant) causal proximity may be termed a ‘mere condition’. It is, in other words, a factor ‘without which’ the loss would not have been incurred, but it is factor to which, for one reason or another, the law attaches no causal responsibility in terms of liability in damages.

331   [ 2001] All ER Vol.4  p.117
Again in *Fair Child v. Glenhaven Funeral Service Ltd.* 333 The House of Lords again qualified the but–for test to allow recovery in a case where it was impossible on the strength of scientific evidence to determine which one or more of several employees, all admittedly, is breach of duty, which had caused the claimant to suffer a fatal illness. These cases suggest that although the but-for test is based on notions of the limits of individual responsibility, and in particular on the percept that the defendant should not be liable for a loss of ensuring that the victim of tortious conduct is fully compensated for losses caused by fault. As Lord Nicholls of Birken said, that even the sophisticated versions of the ‘but for’ test cannot be expected to set out a formula, the mechanical application of which will provide infallible guidance on casual connection for every tort in every circumstance. In particular, the but-for-test can be exclusionary. 334 The test for reasonable foreseeability, like that of but-for cause, is plainly based on court’s perception that an individual should not be made liable in tort for damage beyond. This is the development of law relating to causation and damage. The principle of But-For-Cause is relevant in this context.

**a. But-For-Cause**

But for cause is a rule of evidence under medical liability. Under the but for test the claimant must prove the existence of a causal link on the balance of probabilities, which is taken to mean a likelihood of more than 50 per cent. If the court finds that it was as likely as not that the injury would have occurred without the defendant’s negligence, the action will fail even if there is an admission of carelessness. A glance at the but-for test was made in *Bolitho v. City and Hackney Health Authority*, 335 where the court said that the defendant cannot escape liability

---


335 Supra n.75
by saying that the damage would have occurred in any event because he would have
committed some other breach of duty thereafter. This is simply saying that the court
will seek to establish, as best it can, what would have happened but for negligence,
both for actual and hypothetical, of the defendant.

In *Wilsher v. Essex Area Health Authority*[^336] the House of Lords was highly
critical of the approach set out by Lord Wilberforce, explaining it is a case in which
there was sufficient evidence to make the necessary interference of a casual link
between fault and damage. Medical evidence established no fewer than six separate
potential causes of the plaintiff’s blindness, of all of which, the exceptions of the
excessive dose of oxygen were inherent in his condition as a premature birth. The
House of Lords, reversing the court of appeal, held that causation had not been
adequately established, a failure to take preventive measures against one out of five
possible causes is not evidence as to which of those five caused the injury. So this
is the present development of law relating to but-for cause. The next is the
position of law relating to multiple defendants and indeterminate cumulative causes.

b. Multiple Defendants; and in Determinate Cumulative Causes

Multiple defendants; and in determinate cumulative causes is the most
relevant aspect of medical liability. In other words when an injury occurred
because of the fault of number of defendants, strict application of but for test has
been modified to avoid the compensation for the claimant.

The first situation to consider is that in which the claimant’s injury could only
have been caused by the fault of one out of several careless defendants, in
circumstances where the individual in question cannot be identified; this may
be called the case of ‘indeterminate causes. The best illustration is provided by two

similar cases decided by the United States and Canada *Summers v. Tice* and *Cook v. Lewis* 337 respectively. In each case the plaintiffs was a shot by one bullet which was fired by one of two defendants who were hunting, each of whom had been careless in aiming his gun in the plaintiff’s direction. There was no meaning in telling whose gun the shot was fired. The courts adopted the solution of reversing the burden of proof, so that each defendant had to show that he did not cause the injury. In the absence of such proof both defendants were held liable.

The principle developed on this aspect is joint tort feasors are held jointly and severally liable, that is to say each one is potentially responsible for the full amount of the loss. A defendant held liable to the full extent might then seek contribution from another. The result seems just, since it enables the claimant to receive full compensation and shift his loss to the two defendants jointly, but it cannot be reconciled with a strict application of the balance of probabilities test.

The difficulties inherent in the but-for-test were posed even more sharply in *Fairchild v. Glenhaven Funeral Service Ltd.* 338 A number of claims were brought by victims of mesothaloma, a fatal disease which is contracted by inhaling asbestos dust by several successive employees. However, it was possible to show which employer had caused the exposure, which led to the claimant’s illness. Lord Nicholl also acknowledged that ‘the court was applying a different and less stringent test’ from the normal but; for test. 339 According to Lord Hoffmann held that it is highly necessary to formulate a different causal requirement in this class of case. 340 Next relevant aspect relates to rules of evidence. *Res ipsa* Rule is the main rule of evidence discussed.

337 [1948] 2 All ER p.119.
338 [1989] 2 All ER 545.
c. Res ipsa Rule

This is the concept of evidentiary value relating to medical negligence as a rule of evidence. Initially in USA the court applied what was called the “locality rule” in deciding the standard of care of a doctor. This rule as applied was that a physician’s care would be judged only by the skill and care generally possessed by similar practitioner in the same or similar locality. This ‘locality rule’ originated over hundred years ago. The rationale for the rule was essentially to protect the doctor practicing in small, rural area from being evaluated and compared to his or her more sophisticated and scientifically advanced city colleagues. In essence the rule was made to compensate the manifest inequality existing at that time between physicians practicing in remote rural area and those in large urban cities. Eventually, this rule came under attack and was given up, in the light of modern condition where nearly uniform quality of medical school training was imparted throughout USA and there was wide dissemination of a new and progressive medical techniques, discoveries and procedures via professional journals, conference and the media.

Now a so called national standard has been adopted among medical specialist. The national standard is a fairly flexible rule which is basically defined as the degree of knowledge and concomitant medical skill that a physician under the same or similar circumstances should ‘reasonably’ possess, that is the “standard” by which the physician should be judged.

In India the court has never applied the “locality rule”, perhaps due to the fact that “medical negligence” is a phenomenon, which came into being not too long ago. It is not applied in India. Res ipsa is a rule of evidence, which purports to enable the judge to arrive at the right verdict so that justice may not be miscarried.

341 Supra, n.338
342 Supra, n. 339
343 Ibid.
The rule was first applied in *Byrne v. Boudle*, 344 where it was remarked that a presumption of negligence arises from the occurrence of accident itself. Chief Justice Earl with Pollock C.B, Barnwell B. Channel B and Pigott B said that “there must be reasonable evidence of negligence, but when the thing is shown to be under the management of the defendant or thing does not happen, if those who have the management, use proper care, it affords reasonable evidence, in the absence of explanation by the defendant, that the accident arose from want of care. 345

In the application of “*res ipsa loquitur*” plaintiff has to prove mere happening of the accident which speaks of negligence. The rule of evidence tends to enable justice to be done when the facts bearing on causation and on the care exercised by the defendant are at the outset unknown to the plaintiff but known to the defendant. The maxim comes into operation (1) when the occurrence is one which would not have happened in the ordinary course of things without negligence on the part of somebody other than plaintiff and (2) the circumstances point to the question that of negligence of the defendant rather than that of any other person. 346 The res speaks because the facts stand explained, and therefore, the natural and reasonable, not conjectural, inference from the fact show that what happened may be reasonably attributed to some act of negligence on the part of some body; that is some want of reasonable care under the circumstances. It means that the circumstances are so to speak, eloquent of negligence of somebody who brought about the state of things, which is, complained of. 347

This rule is applicable in the cases where the occurrence of injury is such that most probably it appears to be the result of negligence to somebody and probably the defendant is the person who is responsible. To be more precise, it can be said that the injury must be of a nature which could not be which caused without

---

344 (1863) 159 E.R. p. 299-301
346 *Allan v. New Mount Sinai Hospital* [1986] 28 All ER p.356,364 per London J.
negligence, and for the application of maxim, essential element is that there must have been an occurrence which speaks of negligence, that is to say, raises inference that there was negligence of defendant. In many situations, several members of medical profession are involved in treatment. It is very difficult in such cases to attribute the cause of injury to the negligence on the part of a specific person. The injury must not be due to any voluntary action or contribution on the part of the plaintiff, which was the responsible cause of his injury. Though there are conflicting views on application of the maxim to the cases where several persons are involved the rule in Hillyer’s case which was approved in Gold v. Esses County Council and Cassidy v. Ministry of Health, still holds good. ‘Res ipsa loquitur’ has relieved the plaintiff from unnecessary burden of proving which was impossible to prove for him.

The other fact that contributed to the application of the doctrine, is that when act contains medical and surgical procedure which are common that the layman knew that if the procedures are a properly conducted untoward result could not occur. And in others medical men (when it was possible to get them to admit it) from their specialized knowledge knew that without negligence the result would have been a good one.

In various jurisdictions, the rule has been opposed for the reason that it lays unnecessary burden on the operating surgeon or medical practitioner to give explanation as to the accident or injury caused by their conduct. But if we compare the problem of plaintiff with that of doctor, the rule is more beneficial to the patient, who being ignorant of the medicine has to prove the negligence of defendant medical practitioner to win the case. The maxim as such finds no place in the body of Indian Evidence Act but in 1970, California Evidence code was amended so as to enact section 646 to make a room for res ipsa loquitur.

348. (1978) All ER Vol.3.
349. Salgo v. Leland Standford Jr.Universal Board of Trustee (1957) 134 Cal App.2d 560
The classic elements of a *res ipsa loquitur* claim include (1) a type of injury that does not ordinarily occur in the absence of negligence (2) an injury that was caused by an agency or instrumentality under the exclusive control of the defendants (3) an injury that was not caused by any voluntary action or contribution on the part of the plaintiff.\(^{350}\) For example in *Ybarra v. Spangard*\(^ {351}\) the patient underwent surgery for an appendectomy and eventually lost the use of his arm.

Two examples of cases applying *res ipsa loquitur* after a bad outcome with no proof of deviations from the standard of care are *calvin v. Jewish Hospital of St. Louis*\(^ {352}\) and *Shannon v. Jaller*\(^ {353}\) the court applied the doctrine where the patient sustained paralysis in the arm after undergoing lower back surgery. In Shannon, the doctrine was applied when the patient suffered partial paralysis in her fingers and pain and injury in her wrists and hands after surgery to remove calcified deposits in her shoulder.\(^ {354}\)

In Texas, medical malpractice reformers have taken note of the conclusion and misunderstanding inherent in the doctrine *res ipsa loquitur*\(^ {355}\) and have severely limited its application.\(^ {356}\) Another relevant area is duty of court to adjudicate medical negligence offence.

**W. Duty of Court**

The role of court in the process of appreciation of evidence and adjudication process has been discussed here. The doctrine of informed consent to therapeutic medical treatment is developing in England, while in America, medical law has


\(^{351}\) 1995 All ER Vol. 2 p. 687.

\(^{352}\) All ER 1992 Vol. 2 p. 146.

\(^{353}\) ( Ohio App. 2d 206, 217 N.E. 2d 234 (1966)

\(^{354}\) Jim M. perclude, Res Ipsa Loquitur Applicability of malpractice cases in Texas, *10 Tex. TECH. REV.* p. 371-


\(^{356}\) *Ibid.*
been the most controversial issue for the last two decades. In Canada, LINDEN j.
Observed in *white v. Turner* 357 as follows:

“The exercise of defining the scope of the duty of disclosure is now a
complicated one for the court, requiring much time, effort, thought and evidence. The
co-operation of the medical profession will be vital to the task. The court will as
always, move very cautiously in this area. In most cases, the court will probably
accept as reasonable the customary practice of the profession as to disclosure, since
they are, after all, based on experience, common sense, and what doctors perceive
their patients wish to know.”

The doctors are held to be negligent in failing to carry out the recommended
test to discover the side-affect of the drug, but they having obtained incipient
consent to general treatment, are not liable for exercising his discretion to use the
drug. A doctor, thus, may be liable in negligence if he fails to follow proper
professional standard of care when obtaining his patient’s consent.

In an English case, a thirty-year old woman patient admitted in the hospital
with the ruptured membranes having spontaneous labour beyond the expected date
of birth, had refused to submit herself to caesarian operation on religious grounds.
The court exercised its inherent jurisdiction to authorize the surgeon and the staff of
the hospital to carry out an emergency caesarian section operation on the patient
contrary to her beliefs, if the operation was vital to protect the life of the unborn
child.

357 Meisel., Appointing an agent to make medical treatment Choice , *Columbia Law Review*,
Vol:84, May 1984, p.985
X Advantage of Appointing a Medical Agent

Appointment of a medical agent on behalf of a patient is prevalent in America. The agent could ask question, assess risks and costs, speak to friends and relatives of the patient, consider a variety of therapeutic options, seek the option of other physicians, evaluate the patient’s condition and prospect for recovery, in short engage in the same complex decision making process that the patient himself would undertake if he were able. The appointing authority would retain the same power to intervene if an agent proposed to take steps plainly inconsistent with the welfare of a patient.

Recently the States of Delaware, California, and Virginia –have enacted legislation explicitly authorizing an individual to appoint an agent –to make medical decision in the event that the appointer subsequently becomes decisions incapacitated. He is required to carry out responsibilities to the patient in a manner entirely consistent with agency principles.

There is additional evidence that medical decision-making cannot properly be classified as a non-delegable act. Traditionally the law has charged a parent or another person standing on behalf, with the duty to make medical decision for a child. This is based on the theory that minors lack capacity to give consent.

However, if a parent or guardian is temporarily unavailable to give necessary consent to treatment of a minor or incapacitated adult in his custody, many States, specifically provided that the parent may delegate to another his power

358 Ibid
359 Ibid.
361 Bomer v. Moran All ER (1992) 2 p.126
of consent.\textsuperscript{363} Finally a California statute required that a principal must expressly authorize the agent to make medical decisions.\textsuperscript{364} The power may not be implied from a “general power of attorney”, “authorizing the agent to perform “all acts” of the principal. This precaution is to prevent inadvertent delegation of medical decision making authority.\textsuperscript{365}

The principal can determine when the agent’s power takes effect and when it ends.\textsuperscript{366} Thus, if the power of attorney so provides, the agents authority could be invoked immediately and automatically whenever substituted decision-making becomes necessary, avoiding the delay, the cost and the distress to the patient involved in a formal incompetence haring. Furthermore, the principal not the courts, retain complete control over the scope of the agent’s authority. In effect, the durable power of authority gives the principal the opportunity to create a limited, voluntary, inexpensive, gildedship.\textsuperscript{367} This is related to appointment of medical agent in America. This can be considered for adoption in India. Another innovative reform that was brought about in America was with respect to medical audit which is being discussed below.

\section*{Y Medical Audit}

The systematic form of quality assessment became known as ‘medical audit’. Medical Audit was introduced in 1991 in America, as part of the reform proposed in the white paper working for patient, which followed the Prime Minister’s review of the NHS in 1988. Although not given legal face in the NHS

\begin{itemize}
\item \textsuperscript{363} “An Attorney infact… may not make health care decision” unless…. The durable power of Attorney specially authorizes the attorney in fact to make health care decision” Cal-civ.code 2432 (a) (1) (West Supp.1987)
\item \textsuperscript{364} Prior v. Hager W.L.R. Vol.2 page 167-174. This precaution would also support the preference for splitting Guardianship rather than making an agent the sole guardian ‘general power of Attorney’ is consisted with the rate that the terms of a power of attorney will be strictly construed.
\item \textsuperscript{365} \textit{Ibid}
\item \textsuperscript{366} \textit{Ibid}
\item \textsuperscript{367} Durable power of Attorney Act prefactory note, U.L.A. 511 (1985)
\end{itemize}
168

The regional Health Authorities have a dual role. They are required to facilitate the introduction of medical audit within their region: distributing money and advice to Health district and specifically supporting audit in certain defined area of health care. They are also required to monitor the organization and implementation of medical audit in Health District-ensuring that it is both adequately organized and effectively implemented.

It is the existence of additional external pressures which provided the de facto mandatory framework to “encourage the implementation of medical audit. These are reviewed below and emanate from within the medical profession itself: from the fact that medical care is now the subject of contract with purchasing Health Authorities Service. This is concept of medical audit in USA. This can also be adopted in India for the prevention of medical negligence offence.

---


369 Ibid.
Conclusion

These are the main theoretical concepts of tortious liability. Under the tort law a heavy liability is attributed to the plaintiff to prove the case beyond the preponderance of probabilities. It is difficult for the plaintiff to prove the case in the civil court, as the entire burden is on the plaintiff. One of the most important obstacles faced by the plaintiff in relation to a medical negligence case is the inaccessibility to medical evidence which is under the exclusive control of hospital authorities and doctors. Another complication relate to the lack of medical knowledge regarding identification of medical evidences. The theoretical aspect of tortious liability is highly complicated for an ordinary patient to process a case against doctors and hospital authorities. Hence they prefer the facility provided by the consumer law. Medical service is now incorporated under deficiency of service within the jurisprudence of consumer law. The theoretical concept of consumer liability is discussed in the following chapter.
CHAPTER-IV