

REMEDIES FOR **MEDICAL NEGLIGENCE**

In the early nineteenth century it was indeed unusual act for patients to sue their doctors in the court of law. Doctors are considered to be visible gods who can renew the life of persons who languishing from diseases, injuries and defects. They are trustworthy persons. A patient who consults a doctor will presume that he is skilful and competent to heal his disease¹. Practice of medicine is capable of rendering noble service to humanity provided due care, sincerity, efficiency and professional skill is observed by the doctors. In the area of patient-doctor relationship two important models dominate namely one is based on *Paternalism* and other is founded on the doctrine of *informed consent*². In UK, the paternalistic model of the physician-patient relationship has been a dominant feature³ in the medical profession since its inception. This has been duly recognized in the English law through the famous **Bolam's** case which states that a doctor is not liable in negligence medical claim when he acted "in accordance with a practice accepted as proper by a responsible body of medical men, skilled in the particular art"⁴. In the United States, the doctor-patient relationship is based on the doctrine of informed consent⁵. A patient must be given all the required information about the nature of treatment, risks involved and the feasible alternative, so as to enable him her to make a rational and intelligent choice whether to proceed with treatment or surgery or not. In informed consent of the patient concerned is not obtained, then, the doctors will be liable. However, today, the patient-doctor relationship has almost diminished its fiduciary character; medical service has become a purchasable commodity and this business attitude has given an impetus to more and more medical malpractices and instances of clinical negligence. In this context, the question of patient protection has become highly significant in the medical profession. This chapter deals with various legal provisions in respect of enforcement of liability of health care providers. A victim of medical negligence who intends to sue an erring health care provider has the following options.

¹ Benjamin MS, and Dr. Raju CB, "Criminal Clinical Negligence: who watches the life saviour- a critical appraisal, Karnataka Law Journal, 2007(1) p.27.

² Nayak RK, "Medical Negligence, Patient's Safety and the Law", Regional Health Forum- Vol. 8, No.2 2004, p. 15.

³ See generally Chapman, "Physicians, Law and Ethics" (1984) pp. 220-223.

⁴ Bolam Vs Friern Hospital Management Committee (1957) 2 All ER 118 at 121.

⁵ Schloendorff Vs Society of New York Hospital, 211 N.Y 125 N.E. 92 (1914)) as per Justice Cardozo).

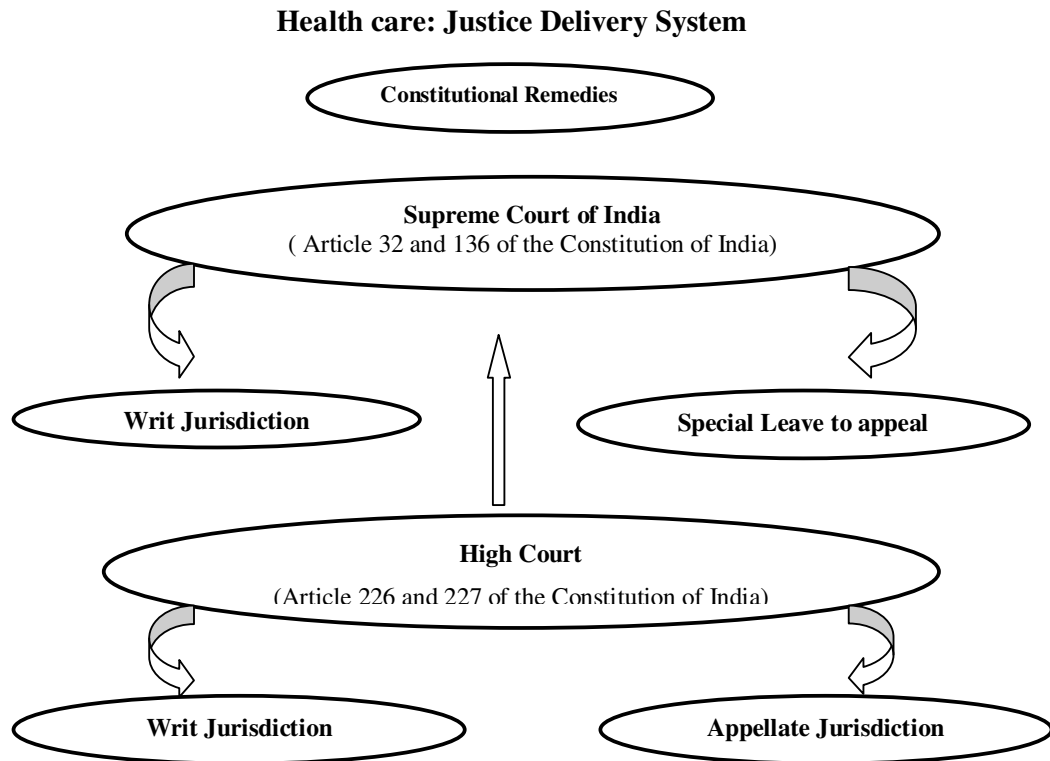
- a) **Compensatory action:** seeking monetary compensation before the Civil Courts, High Court or the Consumer Dispute Redressal Forum under the Constitutional Law, Law of Torts/Law of Contract and the Consumer Protection Act.
- b) **Punitive action:** filing a criminal complaint against the doctor under the Indian Penal Code.
- c) **Disciplinary action:** moving the professional bodies like Indian Medical Council/State Medical Council seeking disciplinary action against the health care provider concerned.
- d) **Recommendatory action:** lodging complaint before the National/State Human Rights Commission seeking compensation.

5.1. LIABILITY OF HEALTH CARE PROVIDER IN THE CONSTITUTIONAL LAW

Strictly speaking, the Constitution of India does not guarantee any special rights to the patient. The patient's rights are basically derivative rights, which emanates from the obligation of the health care provider. The Supreme Court in various cases has viewed that the right to life as enshrined in Article 21 of the Constitution of India includes the right to health and medical treatment. The right to life would be meaningless unless medical care is assured to a sick person⁶. Article 19(1) provides six fundamental freedoms to all its citizens which can be restricted only on grounds mentioned in Clauses (2) to (6) of Article 19 of the Constitution. These fundamental freedoms can be effectively enjoyed only if a person has healthy life to live with dignity and free from any kind of disease or exploitation which further ensured by the mandate of Article 21 of the Constitution. When breach of this right occurs, the health care provider will be held liable for negligence.

⁶ Sharma MK, "right to Health and Medical Care as a Fundamental Right" AIR 2005, p. 255.

5.1.1. Structure⁷



5.1.2. Procedure and enforcement of right through remedies

Wherever there is infringement of right to life and personal liberty the person aggrieved or any public spiritual individual can move the Supreme Court or High courts by appropriate proceedings for the enforcements of rights so infringed by the state action. The courts are empowered to grant compensatory relief if the state fails to preserve the life or liberty of the citizen.⁸ Award of compensation for the breach of Article 21 of the Constitution is not only constitutional power but also to assure the citizens that they live under a legal system wherein their rights and interests are protected and preserved⁹. The courts have the obligation to protect the rights of citizens, since the courts and laws are made for the people. Therefore, they are expected to respond to their aspirations¹⁰.

⁷ Adopted from Legal frame work for health care in India, edited by Prof. S.K. Varma, ILI, 2002, Lexis New Butterworths, New Delhi, P. 13

⁸ It was in Rudul Shah V State of Bihar (AIR 1983 SC 1086) in which the Supreme Court for the first time set up an important landmark in Indian Human Rights Jurisprudence by articulating compensatory relief for infraction of Article 21. Since then the court started awarding monetary compensation as and when the conscience of the court was shocked.

⁹ AIR 1998 Journal 154

¹⁰ D.K. Basu V State of West Bengal AIR SC 610 at 625.

5.1.3. Right to move the Apex Court and High Courts

Any person whose rights have been infringed can move the Supreme Court under article 32 of the Constitution. The court has liberalized traditional rule that “only a person who has suffered injury by reason of his legal right or interest is entitled to seek judicial redress¹¹. The Supreme Court has enlarged the rights of citizens under which any person or group of person or public spiritual individual may move the Supreme Court or High Court for the enforcement of fundamental rights of people who are unable to approach the court due to their illiteracy or social or economic condition. The Supreme Court shall have power to issue directions or orders or writs, including writs in the nature of habeas corpus, mandamus, prohibition, quo-warrants and certiorari, whichever may be appropriate, for the enforcement any of the rights conferred by this part¹². Similarly, one can move the High Court by appropriate proceedings for the enforcement of the rights conferred and guaranteed under the constitution and other laws¹³.

5.1.4. Points for Consideration

- a) Whether Article 21 of the Constitution mandates health care as fundamental right?
- b) Is it obligatory upon the doctors in government hospital to conduct medical examination of victim of accident or crime without it being referred to them by the police?
- d) Whether the right to cure ailment includes ‘faith’ healing?
- e) Whether the health insurance of workmen can be claimed as a fundamental right?
- f) Whether the court can grant interim compensation to the dependents of the victim of negligence of the governmental staff?

5.1.5. Right to life and jurisprudence of personhood:

The right to life is guaranteed under Art. 21 which states that “no person shall be deprived his or personal liberty except according to procedure established by law”. We read literally, it empowers the state to interfere with the enjoyment of life and liberty under the pretext of procedure established by law¹⁴. Article 21 received a new

¹¹ Ibid note 7, at page 14.

¹² Article 32 (2) of the Constitution of India.

¹³ Article 226 of the Constitution.

¹⁴ As interpreted in AK Gopalan Vs State of Madras AIR 1950 SC 27.

dimension in Maneka Gandhi Vs. Union of India¹⁵ when by its interpretation, the Supreme Court changed the scenario from one that calls for procedural rights to one that provides for substantive rights. Now, the state is mandated to provide to a person all rights essential for the enjoyment of the right to life in its various perspectives¹⁶. The right to health and access to medical treatment has been included in the plethora of rights brought under the ambit of Article 21¹⁷. The philosophy of the right to life enshrined in Article 21 enlarges its scope to encompass human personality with invigorated health which is a wealth to a person to earn his livelihood, to sustain the dignity of person and to live with dignity and equality¹⁸. Lack of health denudes a person of his livelihood¹⁹. The following cases show the various norms lay down by the Supreme Court in regulating health service.

5.1.6. Constitutional Right to Health Care

5.1.6.1. Public Health: In Vincent Pani Kurlnagara Vs. Union of India²⁰ it was contended that matter of public health is incorporated only in Directive principles and they are not enforceable before the court of law, the Supreme Court observed: “maintenance and improvement of public health have to rank high as these are indispensable to the very existence of the community and on the betterment of these depends the building of the society which the constitution makers envisaged. Attending to public health in our opinion, therefore, is of high priority – perhaps the ones at the top.” For the have nots and weaker sections of society, the right to health and medical care is a part of right to life²¹. In C.E.S.C. Limited vs. Subash Chandra Bose the court emphasizes the need to provide medical facilities for improving the general standard of health of workmen consistent with human dignity and right to life and personality. The Court observed with the right to health is fundamental human right to workmen. Health is thus a state of complete physical, mental and social well being. Health is wealth and strength of a workman, which is an integral facet of right to life enshrined in Article 21²². However, the remedy for injury sustained by

¹⁵ AIR 1978 SC 597; (1978) 2 SCR 621; (1978) 1 SCC 248.

¹⁶ Jagdish Swaroop and Dr. L.M. Singhvi, Constitution of India, 2nd Edition 2007, Vol. 1, Modern Law Publications, New Delhi, p. 1099.

¹⁷ AIR 1997 Journal Section, 103 at p. 103, 104).

¹⁸ Consumer Education and Research Centre Vs. Union of India, AIR 1995 SC 922; (1995) 1 JT 636

¹⁹ Bharath Kumar K. Palicha Vs. State of Kerala, AIR 1997 Ker. 291; (1997) 2 ker LT 287

²⁰ AIR 1987 SC 990.

²¹ AIR 2005 Journal Section p. 256.

²² AIR 1992 SC 573.

workmen is already provided in Workmen Compensation Act, 1923, but the remedy of compensation in the said Act is of limited application. It is available only during the course of employment and for injuries or diseases specified in schedule III of the Act.

5.1.6.2. Workers right to clean environment, health insurance and health care facilities:

The expression 'life' assured in Art. 21 does not connote mere animal existence or continued drudgery through life. It has much wider meaning which includes right to livelihood, better standard of living, hygiene condition in the work place and leisure facilities and opportunities to eliminate sickness and physical disability of the workmen²³. Health of the workman enables him to enjoy the fruits of his labour, to keep him physically fit and human right to protect his health. In C.E.S.C Limited Vs Consumer Education and Research Centre, it was viewed that health insurance, while in service or after retirement was held to be a fundamental right and even private industries are obligated to provide health insurance to the workman²⁴.

5.1.6.3. Medical treatment abroad:

A question arises: whether a workman can claim medical treatment outside India? This issue has been decided by the Supreme Court in State of Punjab Vs. Ram Lubhaya Bhagga wherein it ruled that the treatment of disease in abroad country would be permissible where satisfactory treatment is not available in the country. Such treatment should be recommended by the State Medical Board prior approval of the State Medical Board shall be a pre-requisite in such cases²⁵.

5.1.6.4. Constitutional obligation to provide medical services:

The Supreme Court in Paschima Banga Khet Mazdoor Samity & Others Vs. State of West Bengal & Another²⁶ while widening the scope of Art. 21 and governments responsibility to provide medical aid to every person in the country held

²³ C.E.S.C Limited Vs Consumer Education and Research Centre JT 1995 (1) SC 636.

²⁴ State of Punjab vs. Ram Lubhaya Bagga, AIR 1998 SC 1703 and Kirloskar Brothers Ltd vs. Employees State Insurance Corporation AIR 1996 SC 3261.

²⁵ AIR 1998 SC 1703.

²⁶ 1996 4 SCC 37.

that article 21 imposes an obligation on the state to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the state are duty bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment, results in violation of his right to life guaranteed under Art. 21. The petitioner should, therefore, be suitably compensated for the breach of his right guaranteed under Article 21 of the Constitution. After considering facts and circumstances of the case compensation of Rs. 25,000 was awarded.

Emphasizing the importance of Directive Principles of State Policy in *Akhila Bharatiya Soshit Karamcharai Sangh Vs. Union of India*²⁷, the Supreme Court pointed out that fundamental rights are intended to foster the ideal of a political democracy and to prevent the establishment of authoritarian rule, but they are of no value unless they can be enforced by resort to courts. The directive principles cannot, in the very nature of things be enforced in a court of law, but it does not mean that directive principles are less important than fundamental rights or that they are not binding on various organs of the state.

5.1.6.5. Professional duty to extend helping hand to ‘victims of accident.’

The Supreme Court in its landmark judgment in *Pt. Paramananda Katara Vs. Union of India & others*²⁸ ruled that every doctor whether at a governmental hospital or otherwise has the obligation to extend his services with due expertise for protecting life. No law or state action can intervene to avoid or delay, the discharge of the paramount obligation cast upon members of the medical profession. Any law of procedure or statute which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way. The court laid, down the following guidelines for doctors, when an injured person approaches him:

i) Duty of a doctor when an injured person approaches him:

Whenever, a medical man is approached by an injured person, and if he finds that whatever assistance he could give is not really sufficient to save the life of the

²⁷ 1981 1 SCC 246..

²⁸ AIR 1989 SC 2039.

person, but some better assistance is necessary, it is the duty of the man in the medical profession so approached to render all the help which he could, and also see that the person reaches the proper expert as early as possible.

ii) Legal protection to Medical practitioners:

Where a doctor proceeds with treatment to an injured who appears or is brought before him, does not amount to breach of the law of the land. Zonal regulations and classifications operate as fetters in the discharge of the obligations, even if the victim is elsewhere under the local rules and regardless of involvement of police. The court has attempted to resolve conflict of duties of doctors and police officers pertaining to investigation of the case. Investigation agency cannot supercede the professional obligation of doctors.

iii) No obstacle on medical practitioners from attending injured persons:

There is no legal bar or impediment on the part of medical professional, when he is called upon to attend an injured person needing his medical assistance immediately. The sincere attempt to protect the life of person is the top priority of not only medical professional but also of the police, or any other citizen who happens to be connected with the matter, or who happens to notice such an incident..

iv) Prevent harassment of doctors:

Taking the judicial notice of incidents where the doctors are being harassed by the police in the guise of investigation and unnecessary delay in the medical evidence by way of frequent adjournments or by cross-examination, the court held that unnecessary harassment of the members of the medical professional should be avoided. They should not be called to the police station to unnecessarily interrogation or for the sake of formalities. The trial courts should not summon medical men unless the evidence is necessary, even if he is summoned, attempt should be made to see that the men in this profession are not made to wait and waste time unnecessarily, the law courts have to respect for the men in the medical profession. The Supreme Court attempts to remove apprehension that prevents medical men from discharging their duty to a suffering person.

5.1.6.6. Faith healing is not included in Article 21:

Article 25, which guarantees right to profess, practice and propagate religion is subject to public order, morality and health. The point is whether a person can claim right of curing ailments and improve health on the basis of his right to freedom of religion. Every form and method of healing will not be permitted to be practiced in public. A healing practice in order to become a profession, it has to guide the proper procedure which must be proved by known and accepted methods, verified and approved by experts in the field of medicines. It is only when a particular form, method, procedure or path is accepted by experts in the medical profession, then such form etc, can be permitted to be practiced in the public interest. The right to health implicated in Art. 21 does not come in conflict or overlap with the right to propagate and profess religion. These are separate and distinct rights. Where the right to health is regulated by validly enacted legislation, the right to cure the ailment through religious practice like 'faith healing' cannot be claimed as fundamental right²⁹.

5.1.6.7. Medical Services in trains

It is a settled rule that right of an Indian citizen to travel inside and outside India is part of his 'personal liberty' under Art. 19. The right to travel include right to travel abroad³⁰. One of the points that arise for consideration of court in R.D. Sharma Vs. Union of India³¹ is, whether the human dignity can be ignored in the train during the course of traveling or journey. This court comes to the conclusion that Indian Railways being a public undertaking is a state as defined in Article 12 of the Constitution. Monopoly upon the Railway Transport is the cheapest mode of travel available to the people of India. It is therefore, under obligation to perform all the duties and responsibilities of welfare state. The court issued directions to reserve a coupe for medical facilities along with a team of doctors and make wide publicity of the medical facilities available.

²⁹ Rajesh Kumar Srivastava Vs. Andra Pradesh AIR 2005 All 175.

³⁰ See Maneka Gandhi's case.

³¹ AIR 2005 Rajasthan 317 (DB).

5.1.6.8. Rape victim's right to get examined by doctors:

The Supreme Court in *State of Karnataka vs. Manjamma* deprecated the tendency of refusal to conduct medical examination of rape victims by doctors in rural government hospitals unless refined by the police. The Court observed:

“We wish to put on record our disapproval of the refund of some government doctors, particularly, in rural areas where hospitals are few and far between to conduct any medical examination of a rape unless the case of rape is refined to them by the police³².”

The court added that such a refusal to conduct the medical examination, necessarily results in a delay in the ultimate examination of the victim by which the evidence of rape may have been washed away by the complainant herself or be otherwise lost. The court, therefore directed that the state must ensure that such a situation does not occur in the future³³.

5.1.6.9. Compensation on humanitarian grounds

The Supreme Court in *AS Mittal Vs. State of UP*³⁴ while dealing with a public interest litigation alleging negligence on the part of the doctors in providing services at an eye camp organized by the Lions Club observed that although intention of the camp was noble but proved a disastrous medical misadventure for the patients. Some 84 patients lost vision due to mistake on the part of the medical practitioner during eye camps. The court awarding compensation on humanitarian grounds pointed out that if any of the victims are eligible for pension under any of the existing schemes in force in the state, their cases shall be considered for such benefit. The court directed the Legal Aid and Advice Boards of UP State to take up this issue and process the claims of the victims for such other benefits which provides aid to the aged, the disabled and the destitute, subject to the condition that the victims satisfy the conditions of those schemes.

The judicial observation from *Vincent Panikurlangara to Pashima Banga Khet Mazdoor Samity* gives a clear picture that access to medical treatment is an integral part of article 21 of the constitution. The approach in Paschim Banga Khet Mazdoor Samity is more dynamic as the state governments are directed to provide

³² AIR 2000 SC 2231.

³³ Ibid.

³⁴ AIR 1989 SC 1571.

medical facilities along with sophisticated medical treatment. Of course, the government may face financial constraints in implementing all these directions but that should not be an excuse for the state to go away from the basic responsibility. In the welfare state it is the primary duty of the state to provide cheap medicine and drugs, better equipped hospitals with modernized medical technological facilities and these things have to be done the state in accordance with the international declarations, mandate of the constitution and the judicial observations. These are the judiciary slogans, but in the reality, even after 55 years of independence, no effective steps have been taken to implement the constitutional obligations upon the state to secure the health and strength of people. The denial of medical assistance to emergency patients by government hospitals on the grounds of non availability of beds or non payment of initial deposits amounts to violation of the right to life. Cases of refusal to admit patients are still common phenomenon in the rural as well as urban areas.

5.2. SEEKING REMEDY UNDER THE LAW OF TORT:

5.2.1. Common law principles

The history of development of law of tort particularly regarding medical negligence litigation is of recent origin in India. It has its foundation in the English common law of *ubi jus ibi remedium*. Indian courts exercise their power to administer law according to ‘justice equity and good conscience’ that indicate that torts are primarily those wrongs for which either statutory remedies are not available or, if available, are inadequate or inappropriate³⁵. In considering actionable negligence, courts are in fact not only identifying the interests which require protection but also the circumstances under which they need to be protected. The interests of aggrieved are preserved and promoted through the grant of a civil right of action for unliquidated damages. In a tort of medical negligence, the cause of action is personal one that is against the person who has been negligent in discharging his duties and that cause of action does not survive against his estate or the legal representative³⁶. There has been slow growth of tort litigation in India in the area of medical negligence. This is primarily due to lack of awareness about ones own rights, the

³⁵ Legal Framework for Health Care in India, Varma SK (edi), 2002, LexisNexis, Butterworths, p.26.

³⁶ See *Balbir Singh Makol vs. Chairman, M/s Sir Gangaram Hospital and others* (2001) 1 CPR 49 wherein the rule of action personalis moritur cum persona is recognized.

spirit of tolerance, the expenses involved and the delay in disposal of cases in civil courts owing to overburden of civil dispute litigations.

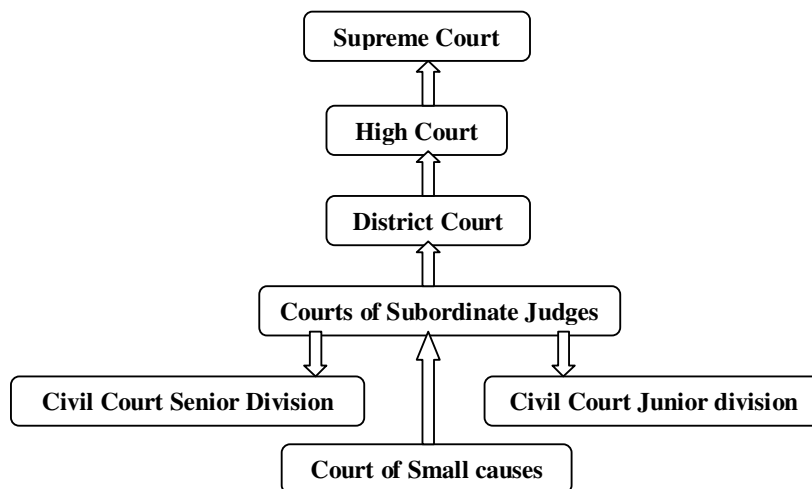
5.2.2. Test to prove medical negligence

The courts in India follow the test with regard to the negligence of a doctor laid down in **Bolam Vs. Friern Hospital Management Committee** in which it was held that a doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

5.2.3. Hierarchy of Justice delivery system:

Under the law of torts action for medical malpractice lies in the civil court where the burden of proof is high and adheres to the strict proof of evidence. Mere complying with the requirements like duty of care, breach of duty and damages will not sufficient to find the defendant doctor being guilty of negligence. The issue of negligence should be proved by the plaintiff with the cogent evidence of medical expert and medical records. The case will fail in the absence of medical witness in support of charge of negligence. The following figure shows the existing hierarchy of adjudicatory mechanisms under the law of torts.

Hierarchy of Justice delivery system



5.2.4. Procedure

The thrust of tortious liability is to compensate the victim for the injury or loss suffered by him. Since it is in the nature of civil proceeding a civil court has to be approached to seek the remedy. There are two purposes behind the tortious liability,

firstly, it provides compensation in terms of money to those injured as a result of negligence of doctors/hospitals, thereby operates as a source of indemnity. Secondly, by imposing sanctions on guilty professionals, it functions as a deterrent to future negligent behavior.

The scope and dimension of law of torts in relation to medical malpractice is wider than the scope of writ jurisdiction of the Supreme Court and High Courts. The victim may move the Apex Court or High Court under the Constitution only when there is infringement of “right to life” envisaged in article 21. The neither the Supreme Court nor any High Court has jurisdiction to entertain case of malpractice against a private health provider. Whereas, the civil court may exercise its jurisdiction over government as well as private health care providers under the tort law. Any person or his family member may institute a suit claiming damages in the court specified herein. According to procedure law, an action for negligence where the total compensation claimed is less than fifty thousand rupees will fall under the jurisdiction of the Civil Judge (junior division). If the amount of compensation exceeds fifty thousand, the litigation has to be instituted in the civil court (senior division). An appeal lies to the District court from the order passed by the civil judge (senior division). An appeal may also be preferred in the High Court of the State concerned, besides preferring appeal in the Supreme Court.

5.2.5. Issues

The question of tortious liability of the medical professional poses the following issues

- a) What are the principles to be considered in determining tortious liability?.
- b) What is the extent of liability of the doctor for negligence?
- c) Is the State vicariously liable for the wrongs done by its employees employed in the public health care service?
- d) What should be the criteria for awarding compensation in case of medical negligence by the health provider?
- e) Under what circumstances the principle of the Ipsa loquiter may be invoked by the victim of negligence?

5.2.6. Substantive principles:

5.2.6.1. Duty of care:

The starting point for determining tortious liability of the health care provider is the duty of care. A legally recognized obligation of health service provider to the patient is duty to take reasonable care³⁷. The duty of care owed by a doctor arises by virtue of the legal concept of “holding out”³⁸ that if the medical practitioner allows or encourages the patient to believe that he is a doctor, then a duty of care is applied which measures that person by the standard of the reasonable doctor in that situation. It is a criminal offence for anyone who is unqualified under the Medical Council Act falsely to represent that he is a medical practitioner³⁹

The duty has many different aspects. In practice, it means effectively that the doctor must take reasonable care for the well being of the patient in all aspects of the medical context in which the doctor is involved⁴⁰. This includes the consultation (or visit) itself⁴¹, giving advice⁴² maintaining confidentiality⁴³, making a diagnosis, referring the patient to a specialist or other doctor and giving or prescribing any treatment⁴⁴. In addition to the obvious aspects of negligence, such as failure to give an injection properly⁴⁵, the duty of care includes other aspects which can be described as non technical for examples administration of drugs and the duty that includes informing the patient of how the treatment is to be carried out⁴⁶ and subsequent adverse effects⁴⁷, communicating the relevant and appropriate risk to the patient⁴⁸ or what went wrong⁴⁹ communicating relevant information to other medical personnel⁵⁰ or for junior has hospital doctors to call in more senior colleagues if necessary⁵¹.

³⁷ Andrew Fulton Philip, *Medical Negligence Law Seeking a Balance*, 1st edition, 1997, Dartmouth Publishing Compnay, Vermont (USA) p. 14.

³⁸ See *Dickson Vs. Hygienic Institute* (1990) SC 552; *R Vs Bateman* (1925) 94 LJKB 791.

³⁹ *Supra* note 37 at p. 15.

⁴⁰ Jones MA, *Medical Negligence*, 2nd edition, Sweet and Maxwell (1996) chs. 2-4.

⁴¹ *Morrison and others vs. Forsyth* (1995) 6 Med. LR 6.

⁴² *Professional Conduct and Discipline: fitness to practice*, General Medical Council, para 77.

⁴³ *Tucker vs. Tees Health Authority* (1995) 6 Med LR 54.

⁴⁴ *Sidaway vs. Board of Governors of the Bethlem Royal Hospital* (1985), All ER 643.

⁴⁵ *Hunter vs. Hanley* (1955) SC 2000.

⁴⁶ *Clarks vs. Adams*, (1950) 94 SJ 599.

⁴⁷ *Fowlers vs. Greater Glasgow Health Board* (1990) SLT 303.

⁴⁸ *Moyes vs. Lothian Health Board* (1990) SCT 444.

⁴⁹ *Supra* note 47.

⁵⁰ *Coles vs. Reading and District Hospital Management Committee* (1963) 107 SJ 115.

⁵¹ *Chapman vs. Rix* (1994) 5 Med. LR 239.

5.2.6.2. Standard required for duty to take care:

To hold a health professional liable for negligence, what is important standard is the want of competent and ordinary skill and care that has led to the unpleasant result. There is a presumption of competency in favor of the registered medical practitioner. Where the surgeon who is registered as a medical practitioner causes injury to his patient by way of his treatment, the presumption is that he is competent and the treatment correct scientifically and under the medical literature till the contrary is shown⁵². Din Mohammad J, quoting Bevan on Negligence, observed “a medical man does not undertake that his treatment shall be infallible; and therefore, he is only held to undertake to perform what can be ordinarily done in similar circumstances. If the medical practitioner has the ordinary degree of skill accepted and practiced in his profession, he is entitled to his remuneration although his treatment has failed”⁵³. This point recognizes that medical treatment is neither exact science, nor favorable outcomes can be anticipated.

The test for medical negligence is essentially objective and does not take formal account of a doctor’s experience, level of qualification, the resources available within the doctor’s clinic or hospital⁵⁴. The test is also retrospective; deterrence of negligent conduct is one of the aims of tort law. Where negligence is alleged, it is only the incident in question which is examined. It is argued therefore, the present legal approach is too narrow and has failed to take into account of the sophistication and complexity of modern medicine⁵⁵. Nonetheless, the court has taken very lenient approach while deciding or tackling the issue of liability of the health carer in view of the risk involved in the surgical/medical treatment. In *Hatcher vs. Black*⁵⁶, Lord **Denning** explains law on the subject of negligence against doctors and hospitals in the following words:

“... In the case of accident on the road there ought not to be any accident, if everyone used proper care and the same applies in the factory; but in a hospital when a person who is ill goes in for treatment, there is always some risk, no matter what

⁵² Supra note 37 p.34.

⁵³ V.N. Whitmore Vs RN Rao AIR 1935 Lah 247.

⁵⁴ Jones vs. Manchester Corporation (1952) 2 All Ed 125, where Lord Denning observed: error due to inexperience or lack of supervision are no defence as against the injured person.

⁵⁵ Bainbridge, D.I., “computer added diagnoses and negligence,” 1991, 32 Med. Sci, Law 127, on the introduction of new technology in relation to liability rules.

⁵⁶ 1954 Times 2nd July.

care is used. Every surgical operation involves risks. It would be wrong and indeed bad law, to say that simply because a misadventure or mishap occurred, the hospital and doctors are thereby liable. It would be disastrous to the community if it were so. It would mean that a doctor examining a patient or a surgeon operating at a table, instead of carrying on his work would be forever looking over his shoulder to see if some one was coming with a dagger; for an action for negligence against a doctor is for him like a dagger. His professional reputation is as dear to him as his body, perhaps more so, and action for negligence can wound his reputation as severely as a dagger can his body. You must therefore, find him negligent simply because something happens to go wrong; ... you should only find him guilty of negligence when *he falls short of the standard of a reasonably skilful medical man.*"

Equally pertinent are the observations of Lord Denning in *Roe Vs. The Ministry of Health*⁵⁷ to the following effect:

"It is so easy to be wise after the event and to condemn as negligence that which was only a misfortune. We ought always to be our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risk. Every advance in technique is also attended by risk. Doctors like rest of us, have to learn by experience and experience often teaches in a hardway. Therefore, we must not look at a 1947 accident with 1954 spectacles."

5.2.6.3. Loss or damage:

Where a claim is brought for tort, damage is a necessary element of the cause of action. Where the plaintiff proves that the doctor was negligent but fails to show any injury or damage caused thereby, he will not be entitled to damages and the claim will be dismissed⁵⁸.

5.2.6.4. Causation

In the tort of negligence, it is not enough for the plaintiff to prove that he sustained damage. In addition to establishing the existence of damage, the pursuer must prove that the defendant's negligent act or omission was the actual cause of the damage which occurred⁵⁹. If the pursuer cannot establish so, there is no tort and the action fails. In contract a plaintiff who proves that the defendant was in breach of contract is entitled to nominal damages, but again he will not be awarded substantial damages unless he establishes a causal link between the breach and his loss⁶⁰.

⁵⁷ 1954 2 QB 66.

⁵⁸ Sidhraj Dhadha vs. State of Rajasthan AIR 1994 Raj 68.

⁵⁹ McWilliams vs. Sir William Arrol & Co. Ltd (1962) SC (HL) 70.

⁶⁰ Jones, M.A. Medical Negligence at para 5-10.

Perhaps it is the most problematic stage in a negligence claim under the present law of delict or tort. Once the plaintiff has overcome the difficulties posed by Bolam's case, then, he has to face the hurdle of causation. It is not for the defendant to prove that his negligence did not cause the damage, rather it is for the plaintiff to prove the causal link between the defendant's breach of duty and the damage suffered by him⁶¹. The requirement to prove causation is very essential and at the sometime a big problem with a medical negligence claim, it involves several factors, for example, the plaintiff may have been suffering from an ongoing disease; however, he must still show that medical negligence caused the damage complained of. In some cases where medical evidence is conflicting or where the adequate medical evidence is not available, the court will find that the plaintiff has failed to prove that the defendant negligence was responsible for the ensuing damage⁶².

5.2.6.5. Requirements to prove causation:

The plaintiff in order to succeed in his action, he must show that:

- a) The damage would not have occurred but for the defendant's negligence; or
- b) The defendant's negligence materially contributed to or materially increased the risk of injury; or
- c) If the claim is for negligent non-disclosure, had he been adequately informed he would not have accepted the treatment.

5.2.6.5.1. The 'but for' test:

The plaintiff has to show that the damage or loss which has occurred would not have occurred in any event, if the defendant's conduct is not a cause. However, the defendant's behavior/conduct need not be the sole cause of the damage, there may be other factors which contribute to the damage, it is what is known as 'factual causation'. In *Barnett Vs Kensington and Chelsea Hospital Management Committee*⁶³ wherein the court held that the defendant was negligent as he did not see and examine the deceased, but he was not liable because the medical evidence indicated that even if the patient had received prompt treatment it would not have been possible to

⁶¹ Ibid.

⁶² Loveday vs. Rendon (1990) 1 Med. LR 117.

⁶³ 1969 (QB) 428.

diagnose the condition and administer drug in time to save him. Thus, the negligence did not cause the death.

In **Bolitho's case**⁶⁴ a child was ill in hospital, no doctor attended the child in spite of fervent request made by the night sister. It had been agreed that it was negligent, if a doctor had visited and incubated the child, the cardiac arrest and brain damage that he suffered would have been avoided. But the defendants argued successfully that the plaintiff had failed to prove that if a doctor had come, she would have probably incubated. The defendant's expert stated that he would not have incubated, while the plaintiff's expert stated it would have been mandatory to incubate. Facing with the conflict of medical opinion, the court held that the plaintiff had failed to prove that the outcome would have been different if the defendant had responded to the nurse's call⁶⁵.

5.2.6.5.2. Material contribution to damage:

The courts appear to be relieving the plaintiff from the rigorous of the "but for" test where the difficulty of establishing causation has been a product of scientific uncertainty. In *Bonnington Castings Limited Vs. Wardlaw*⁶⁶, the House of Lords held that the claimant does not have to establish that the defendant's breach of duty was the main cause of the damage unless it materially contributed to the damage. In this case, employers were sued by an employee who had contracted pneumoconiosis (an industrial disease of the lung due to inhalation of dust particles) from inhaling air which contained silica dust at his work place. The main source of the dust was from pneumatic hammers for which the employers were not negligent (the innocent dust). The crucial issue in the case was some of the dust ("guilty dust") came from swing grinders for which they failed to maintain dust extraction equipment. There was no evidence as to the proportion of innocent dust and guilty dust inhaled by the claimant. Nonetheless, the House of Lords drawing an inference of fact that the guilty dust was contributory cause, held that the employers were liable for the full extent of the loss. This case is significant in easing the claimant's burden of proof for the reason that it

⁶⁴ *Bolitho vs. City and Hackney Health Authority* (1993) 4 Med. LR 381; CA; affd (1997) 4 All ER 771, (HL).

⁶⁵ See *Joyce vs. Merton, Sutton and Wandsworth Health Authority* (1996) 7 Med CR, where it was held that the claimant could not show that the surgeon would have operated within the crucial 48 hour period, if the surgeon had been called to the ward to review the patient following the initial operation done on the patient.

⁶⁶ 1956 AC 613.

was a departure from “but for” causation. The claimant need not to prove that the guilty dust was the sole or even the most substantial cause, it was sufficient to prove ‘material contribution’ to the injury or illness.

5.2.6.5.3. Material contribution to the risk:

Following the House of Lords decision in *Bonnington Castings* case, the House of Lords in *McGhee Vs. National Coal Board*⁶⁷ emphasized the list of material contribution to the risk. In this case, the claimant who was working at the defendant’s brick factory contracted dermatitis as a result of exposure to brick dust. The employers were not at fault for the exposure during working hours, but they were in breach of duty by failing to provide adequate washing facilities. It was agreed that brick dust had caused the dermatitis. Therefore, it was held that the failure to provide washing facilities materially increased the risk of the claimant contracting dermatitis. The implication of **McGhee** case is clear or apparent in *Clark Vs. McLennan*⁶⁸ a medical negligence case where the court held that whenever there is a general practice to take a particular precaution against a specific, known risk but the defendant fails to take that precaution, and the very damage against which it is designed to be a protection occurs, then the burden lies on the defendant to show that he was not in breach of duty and the breach did not cause the damage. But this approach has been criticized as opposed to causation⁶⁹.

5.2.6.5.4. Causation and non-disclosure

Where the action is brought for negligence, the claimant must prove that if he had been warned about the inherent risk in the procedure he would not have accepted the treatment. The court applies a ‘subjective test’ to decide the issue whether the plaintiff would not have accepted the treatment in question. At first glance, this test would show unduly favorable to the plaintiff; the case law demonstrates that the courts apply the test stringently⁷⁰. However, there are some cases where this test has been successfully applied and awarded compensation to the claimant. In *Thake Vs*

⁶⁷ 1956 AC 613.

⁶⁸ 1983 All ER 41 (per se Pain J.

⁶⁹ Per se Lord Mustill J in *Wilsher vs. Essex Area Health Authority* (1987) QB. 730 at 752.

⁷⁰ See *Chatterson vs. Gerson* (1981) QB 432; *Mills vs. Potter* (1984) 1 WLR 641 and *Smith vs. Barking, Havering and Brentwood Health Authority* (1994) 5 Med LR 285, where the court remained unconvinced that the plaintiff would not have proceeded with the procedure had she received more information about it.

*Maurice*⁷¹ the court held the defendant liable to pay compensation to the plaintiff who contended that if the plaintiff's wife had been informed that she might be conceived despite of her husband undergoing vasectomy, she would have taken the measure to prevent pregnancy.

5.2.6.5.5. Remoteness and foreseeability

This issue has been considered by the court in medical negligence litigation or in an action for tortious liability of the health professional. It is not sufficient to establish a duty of care, a breach of that duty and loss of a type recognized by law and caused by the breach, in addition to these what is equally important to hold the defendant liable for the loss or damage is that the loss was *reasonably foreseeable* at the time of breach that it could arise⁷². In other words if the loss caused is too remote and as a reasonable man cannot foresee as likely to occur, the tortfeasor is not liable to compensate the loss or injury.

A recent medical case provides good example of the operation of the principles of remoteness and foreseeability. In *R Vs Croydon Health Authority*⁷³, the claimant, a trained nurse, married and of child-bearing age, underwent a medical check up with a view to taking employment with the defendants. The radiologist who interpreted her X rays did not refer her for specialist opinion but simply opined she would not conceive and take up the employment. However, contrary to this, the claimant became pregnant who contended that she was entitled to damages she suffered trauma of pregnancy and had to bear the cost of upkeep of her daughter. The court said that the claimant's domestic life does not fall within the scope of the radiologist's duty.

5.2.6.5.6. The "egg shell skull" rule

This rule is recognized as one of the exceptions to the rule of foreseeability. It signifies that where the claimant suffers from a latent injury or illness which has been caused by the damage inflicted by the defendant, then the defendant is responsible for the additional, unforeseeable damage that his negligence has produced. The

⁷¹ 1986 QB 644.

⁷² Charles J. Lewis; *Clinical Negligence – A Practical Guide* p. 212.

⁷³ 1978 Lloyd's Rep Med. 44 CA.

complainant/claimant is entitled to damages to the full extent of his injury. This is usually referred to as the “thin /skull” or “the egg shell skull” rule. If the claimant has thin skull, the defendant doctor cannot complain that the harm or injury was not foreseeable or beyond the expectation of a normal person. The defendant is considered to be in breach of duty and responsible for the loss⁷⁴. This principle will be applied where the claimant has an unusually weak heart⁷⁵ or a weak back⁷⁶. On the other hand, the egg shell skull rule overlaps with the general principle that the extent of the damage need not be foreseeable⁷⁷ and it is not clear, how does the rule apply where the damage is psychiatric in nature.

5.2.7. Liability of health professionals:

5.2.7.1. Structure of Liability:

The legal principles which we have considered including the duty, standard of care and causation, in general apply to all health professionals irrespective of whether they work in private hospital or government run hospital or practice privately and independently. The general practitioners, who are not employed by the state, are independent contractors. They render or provide primary health care for consideration or free of charge in case of charitable hospital. Yet, the general principles of law governing the tortious liability apply to all the health carer. In other words, the Bolam test applies to health career.

The following tortuous liabilities can be classified into two categories, namely

- (a) Individual liability and
- (b) Institutional or hospital liability.

Individual liability of the medical practitioner arises where the injury or damage is caused by the negligent conduct. The medical man is bound to compensate the victim or the family of the victim or the patient whose death is caused by his wrongful, neglect or default⁷⁸. Even the executors, administrators, heirs or representatives of any diseased medical practitioners are liable to pay compensation

⁷⁴ *Bournhill vs. Young* (1948) AC 92, 119, per Lord Wright.

⁷⁵ *Love vs. Port of London* (1959) 2 Lloyd’s Rep. 541

⁷⁶ *Athey vs. Leonati*, (1997)1 WWR 97, 110 (S.C.C.) where he is haemophilic (a person attacked by a disease transmitted by females only to their male offspring).

⁷⁷ *Smith vs. Leech Brain and Co Ltd* (1962) 2 G.B. 405 wherein the court held that the defendant could have foreseen that a burn would cause cancer and the victim would die. the amounts of damages which the patient suffers as a result of that burn, depends upon the characteristics and constitution of the victim.

⁷⁸ Section 14 of the Fatal Accidents Act 1855.

for any wrong committed by the deceased in his life time and for which he would have been subjected to an action⁷⁹. The Maxim *actio personalis moritur cum persona* is modified in India by section 306 of the Indian Succession Act 1925, which lays down that all rights to prosecute or defend any action for or against a person at the time of his death, survive to or against his administrator or executor, except causes of action for defamation or assault and other personal injuries not causing death⁸⁰.

For the negligent acts like a medical professional, a hospital/health care centre or nursing home can also be made liable. It is called health 'corporate liability' or 'institutional' liability. This kind of liability is of two folds namely, i) primary/direct liability and ii) vicarious liability. Where the negligence claim is targeted at the organization or administration of the hospital, such claims are canvassed as direct liability claims against the hospitals. Vicarious liability is an exception to normal legal principles under which individuals are usually liable only for their own actions and not for those of others. Where a health carer is held liable for the acts of another because of some relationship like employer and employee is called 'vicarious liability'⁸¹.

5.2.7.2. Personal liability of doctors

5.2.7.2.1. Liability of doctor for negligence in failing to exercise proper care and diagnosis:

In *Wood Vs. Thurston*⁸² a drunken man was brought to the casualty ward of a hospital with a history of having been run over by a motor lorry. The surgeon did not examine him as closely as the case required and even failed to use his stethoscope which could have enabled him to discover the patient's true condition. In addition to this, he permitted the patient to return home who after a few hours died. The surgeon was held guilty of negligence in failing to make a proper diagnosis⁸³.

⁷⁹ Section 15 of the Legal Representatives Act 1855.

⁸⁰ *Maharani Dey vs. Debabrata Bardhan* (1984) ACT 95; AIR 1983, Gau 84.

⁸¹ *Supra* note 37 at p. 47.

⁸² 1953 C.L.C. 6871.

⁸³ *Edler vs. Greenwich vs. Deptford Hospital* (1951) *The Times* March 7, the court observed that the doctor was liable for failure to diagnose appendicitis.

5.2.7.2.2. Liability of doctor for error of judgments:

The courts have adopted an approach of extreme caution in determining liability of a doctor for medical malfeasance. Mere error of judgment does not necessarily impose civil liability on the practitioner unless it is shown that he has fallen short of reasonable medical care⁸⁴. It is argued that it will be doing disservice to the community at large if the court were to impose liability on doctors and hospitals for everything that happens to go wrong⁸⁵. The Supreme Court in Laxman Balakrishna Joshi Vs. Trimbak Babu Godbole⁸⁶ ruled that the doctor has discretion in choosing treatment, which he proposes to give to the patient and such discretion is relatively greater in cases of emergency⁸⁷. In Dale Vs. Munthali⁸⁸ the doctor diagnosed the patient as suffering from influenza, when in fact he had meningitis. Yet it was concluded that there was no negligence in failing to diagnose meningitis.

5.2.7.2.3. Liability of a doctor for not advising the patient to approach a better equipped hospital:

In Ram Biharilal vs. Shrivastava⁸⁹ the operation theatre was under repair. There were no facilities for oxygen and blood transfusions, there was no anaesthetist and some life saving drugs were not available. Pipettes (tubes) for testing blood were broken, the saline apparatus was not in order and there were only two staff nurses for a 28 bed hospital. In these circumstances, the court observed that the doctor should not have undertaken such a major operation in a hospital, which was lacking basic facilities. He should have advised the petitioner to approach another hospital which had all the facilities including specialists. The doctor, therefore, failed in his duty of care in undertaking the operation without taking necessary precautions.

⁸⁴ Gopinath vs. Eskaycee Medical Foundation and Another OP. 199/91 dated 10.4.1992 and Hatcher vs. Block (1954) Times 2 July.

⁸⁵ Lord Denning, in Roe vs. Ministry of Health 1954 All ER 131.

⁸⁶ AIR 1969 SC 128.

⁸⁷ In Dr. Ravindra Gupta and others vs. Ganga Devi and others (1993) 3 CPR 255 it was observed that a mistaken diagnosis is not necessarily a negligent diagnosis.

⁸⁸ 1976 78 D.L.R. (3d) 588.

⁸⁹ AIR 1985 MP 150.

5.2.7.3. Institutional liability:

5.2.7.3.1. Primary Liability: In *Hillyer Vs. Governors of St. Bartholomew's Hospital*⁹⁰ the question arose for the consideration of the court was whether the hospital was liable primarily for the injury caused to the patient by the surgeons and anaesthetist during the course of operation. It was held that the surgeons and anaesthetists were not servants as they are professionals and not bound by the directions as to the manner of performance of their work, therefore, as regards these professionals, hospital does not undertake to treat the patients through the agency of the surgeon or anaesthetist, but to procure the services of the surgeon and the anaesthetist. Only the duty undertaken by the hospital is to exercise due care and skill in selecting them and not to ensure that they would not be negligent in treatment. This case makes it clear that the hospital owes a duty to exercise due care in the selection and appointment of its staff including the consulting doctors/surgeons. However, it must be noted that this case was decided during the period where the “control” test for master servant relationship was so applied as to exclude persons who could not direct and supervise the manner of work performed by the doctor. It shows the primary liability of the hospital cannot be linked with the persons exercising professional skill and care, rather primary liability is limited to secure the services of the health professionals, and provide provisions of proper facilities and appliances.

5.2.7.3.2. Vicarious liability

The **Hillyer's** case, the court refused to impose liability on the hospital for neglect act committed by the staff in the course of their employment. The hospitals were able to convince the court that they were not directly dealing with the patients and their role was to entrust the patients under the care of skilled medical practitioner. It was in 1940 onwards when the court started accepting/ recognizing the vicarious liability in the area of medical care. The doctrine of vicarious liability extends the primary liability of the hospital for the wrongs or neglect acts of its servants, irrespective of whether their employment is permanent or temporary or casual paid or honorary, whole time or part time as in the case of visiting physicians or surgeons⁹¹.

⁹⁰ (1909) 2 KB 820, cited in Bournhill, Mobilia and Clifford E. Elias, “The Law of Medical Liability”, the West Publishing Company, Minn, 1995, p. 192.

⁹¹ Ramaswamy Iyer's Law of Torts 8th edition P. 521

In *Gold Vs Essex County Council*⁹² the court held that the hospital liable for the negligent acts of its radiograph and nurses. This judgment removes the distinction created in the Meyer's case and extends the primary liability of hospitals. In *Cassidy Vs. Ministry of Health*⁹³ the court found that a hospital employing two doctors on the contract of service vicariously liable for their negligent acts. In the case of patient himself chooses the doctor and goes to him, the employer-hospital were not be responsible for the acts of the doctor. Because under such a situation, the hospital acts as a facilitator of providing medical care, where the patient approaches the hospital for treatment and by virtue of this consult, obtains the service of the doctor employed there, the hospital is liable for the negligent acts of the doctor employed by it.

In *Cassidy's case*, the court missed an opportunity to discuss the extension of primary liability, rather what the court taken the notice was evaluating law pertaining to master- servant relationship. The majority held that the nurses and doctors who happened to be permanent staff were servants of the hospital and therefore, the hospital would be vicariously liable for the negligence of such nurses and doctors⁹⁴. This court's interpretation impliedly appears to suggest that doctor not serving as permanent staff would not be servants, thus the hospital could not be liable for their negligence vicariously. In the subsequent case of *Roe vs. Ministry of Health*⁹⁵ that the hospital is liable for all its staff, irrespective of whether they are permanent or temporary or visiting, even if they are not servants, they are agents of the hospital. The only exception would be in the case of consultant selected and employed by the patient himself.

The Supreme Court of India in *Spring Meadows Hospital Vs Harjot Ahluwalia through K.S. Ahluwalia*⁹⁶ held the hospital liable to pay compensation for the negligence of its attending doctor who allowed unqualified nurse to give intravenous injection to the patient against the advice of the consultant doctor and thereby contributed to the irreparable brain damage of the minor patient. In *A.M.*

⁹² (1942) 2 KD 293; (1942) 2 All ER 237.

⁹³ 1951 All ER 574.

⁹⁴ (Trehan S.P. and Debashish Sankhari, *Medical Professional Patient and the Law*, TILEM, NLSIU (2nd edition, 2002) p. 45).

⁹⁵ (1954) 2 QB 66.

⁹⁶ AIR 1998 SC 189; (1998) 4 SCC 39.

Mathew Vs. Director, Karuna Hospital⁹⁷ the State Commission directed the hospital to pay compensation to the father of the minor patient suffering from partial disability of the left leg on account of negligence of the unqualified nurse of the hospital in administering injection on the left bullock. In Ranjit kumar Das Vs. Medical Officer, ESI Hospital⁹⁸ the hospital was directed to pay compensation for not giving timely medical treatment to the patient and for refusal to admit the patient of acute pain in abdomen due to non-availability of bed⁹⁹.

5.2.7.3.3. Liability of the Government Hospitals/Doctors

In State of Rajasthan Vs. Vidyavati¹⁰⁰, the Supreme Court observed that the State is vicariously liable for the tortious acts of its servants or agents which are not committed in the exercise of its sovereign functions. The issue is, whether providing or undertaking medical care through the primary health centre constitutes sovereign function of the state. The Supreme Court in Achutrao Haribhau Khodwa Vs. State of Maharashtra¹⁰¹ While overruling the judgment of the High Court makes it clear that the high court has erred in arriving at conclusion that maintaining and running a hospital was an exercise of the state's sovereign function. Disapproving this line of thought, the Supreme Court pointed out that running a hospital is a welfare activity undertaken by the government, but is not exclusive function or activity of the government so as to be classified as one which could be regarded as being sovereign power of the state¹⁰². The state would be vicariously liable for the damages payable on accounts of negligence of its doctors and other employees. Applying this principle, the Supreme Court held the state of Haryana liable for negligence of the doctor in a Government Hospital in performance of sterilization operation resulting in birth of an unwanted child¹⁰³.

⁹⁷ (1998) 1 CPR 39 (Ker).

⁹⁸ (1998) 1 CPR 165 (Cal)

⁹⁹ In Sharifabi I. Syed Vs Bombay Hospital and Medical Research Centre 1998 CCJ 1106 (Mah) the hospital was vicariously held liable to pay compensation for suffering of the patient due to wrong report of MRI.

¹⁰⁰ AIR 1962 SC 933.

¹⁰¹ (1996) 2 SCC 634; (1996) 4 CTJ 950 (SC)

¹⁰² the court referred its earlier decision in Kasturilal's case (AIR 1965 SC 1039) wherein it was noticed that in pursuit of the welfare ideal, the government may enter into many commercial and other activities which have no relation to the traditional concept of government activity in exercise of its sovereign function, similarly, running of a hospital, where the members of the general public can come for treatment, cannot be regarded as being an activity having a sovereign character).

¹⁰³ State of Haryana vs. Santra 2000 CTJ 481 (SC); 1 (2000) CPJ 53 (SC).

The principle of law which emerges is the Union of India and States are liable for damages occasioned by the negligence of employees serving / employed in the services of the Government Hospital as if law would render an ordinary employer liable. The government is required to be impleaded as a party to the suit instituted against a Medical Officer of Government Hospital for damages in respect of neglect act alleged to have been done by him in his official capacity¹⁰⁴. Like a private employer, the state is liable to pay compensation for negligence of its medical practitioners who have committed the wrong in the course of their employment as a public servant. However, the state is not vicariously liable for negligence committed by Medical Practitioners of Government hospitals in course of their private practice or beyond the course of their employment as public officers.

5.3. LIABILITY OF DOCTORS / HOSPITALS IN LAW OF CONTRACT:

Actions of medical malpractice are primarily actions based on the tort of negligence. This is because for majority patients there is weak factual basis in contract.¹⁰⁵ Most patients receive treatment in the state run hospitals and as such there is no direct contract between the government hospital patient and his treating doctor. Whereas, when a patient approaches a private health professional for medical care, the relationship between the hospital and the patient is one of contractual in nature. The private patient is entitled to sue his medical practitioner concurrently in tort and contract, although has not entered into a strictly defined contract with expressly written terms governing the agreement for medical case¹⁰⁶. It has been suggested that there is a contract between a patient and his practitioner even when the medical care is availed of the state run hospital. An agreement of this nature was canvassed in the Canadian case of *Pittman Estate Vs Bain*¹⁰⁷ in which a hospital claimed that there was no contractual relationship with a patient because there was no consideration, the payment to the medical care is not paid by the patient. It was held that patients provide *indirect consideration* for their hospital care. They contributed indirectly through taxes and they also conferred a benefit on a hospital by providing the hospital with patients without which the hospital would not operate. A hospital benefited in

¹⁰⁴ Order 27, R. 5 A of the Code of Civil Procedure 1973.

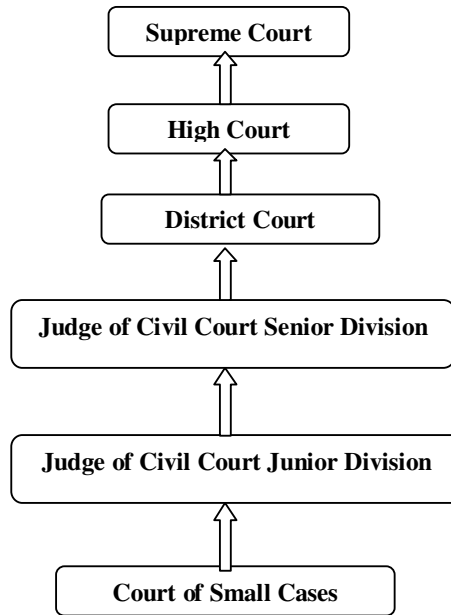
¹⁰⁵ Rodney Nelson-Jones and Frank Burton, *Medical Negligence, Case Law*, (2nd Edition 1995) Butterworths, p. 26).

¹⁰⁶ *Ibid.*

¹⁰⁷ (1994) 112 D.C.R. (4th) 257 (Out. Ct., Gen. Div.)

terms of government financial assistance and enhancement of its reputation when patients choose it for their care. This aspect was sufficient consideration to support a contract between the hospital and the patient¹⁰⁸. In theory, this rationale should apply to patients receiving treatment in the state hospitals, but was rejected in U.K¹⁰⁹ and India¹¹⁰.

5.3.1. Hierarchy of Civil courts:



5.3.2. Procedure for instituting litigation for malpractice

Unlike the Constitutional law and law of Torts, the law of Contract is based upon rules of agreement between the parties for consideration. The scope of liability of the health professional for the breach contractual is very limited in comparing with law of torts. The suit is not maintainable unless the plaintiff proves that he availed of service of the defendant health carer for consideration. No suit can be brought in the civil court for remedies under the law of contract without hiring the service for consideration. Any patient or his legal representative is competent to sue the professional. The procedure followed in Karnataka shows that the suit value of which less than 25,000/- shall be filed in the court of small causes within whose local limit the cause of has arisen. Where the value of the suit exceeds Rs.25,000 but does not

¹⁰⁸ Ibid.

¹⁰⁹ Reynolds vs The Health First Medical Group (2000) Llyod's Rep. Med.240.

¹¹⁰ Consumer Unity Trust Society vs State of Rajasthan CPR 241 1991 (NCDRC).

exceed Rs.50,000 falls within the jurisdiction of the civil court (junior division). If the value exceeds Rs.50,000/- the suit should be filed in the civil court senior division. Appeal lies to the District Court from the order passed by the trial court. The Supreme Court is the highest appellate tribunal in the hierarchy of the civil court under the law of contract.

5.3.3. Issues

- a) What is the significance of the contract in terms of duty of the doctor/hospital?
- b) Is it possible for a professional to give a contractual warranty that he will achieve a particular result?
- c) Can a health professional file a civil suit for recovery of fees charged for rendering medical care?
- d) What are the damages or remedies available for breach of contractual obligation?
- e) Are remedies under law of contract accessible to patients?

5.3.4. Reasonable care and skill

One of the terms of the contract expressly or impliedly to provide a service is the service will be performed with reasonable care and skill¹¹¹. Any health professional who contracts to perform an operation undertakes to carry out the operation with reasonable care; he does not guarantee that at any cost it will prove to be a success. Law does not imply a warranty that the professional will achieve a desired result, but only a term that he will use reasonable care and skill¹¹².

In *Morris Vs. Winsbury*¹¹³ it was argued that the existence of contractual relation between the professional and the patient as to the effect that professional gives personal attention implies that he will bring out the success in the medical treatment. The court observed that the agreement to give personal attention means that he will perform the *operation personally and pay subsequent visits* as are necessary for the supervision of the patient until the discharge of the patient. Delegation of this duty to another doctor would constitute a breach of contract. The contractual duties of

¹¹¹ In *Siddaway vs. Bethlem Royal Hospital Governors* (1985) AC 811, 904, Lord Temple Man said that: the relationship between doctor and patient is contractual in origin, the doctor performing services for consideration impliedly contracts to act at all times to the best interest of the patient).

¹¹² *Greaves & Co. (Contractors) Ltd vs. Baynham* (1974) 3 All ER 666.

¹¹³ (1973) 4 All ER4494 of 501.

care are “non-delegable,” therefore, the doctor is liable for delegation of duties notwithstanding that reasonable care has been taken selecting person and the procedure adopted was success¹¹⁴.

5.3.5. Liability for Breach of Warranties:

To hold a professional for the breach of contract, primarily depends on an agreement between the parties and includes express terms in the written contract. Terms as to payment, the provision of facilities, specify who is to be the treating doctor, and staff will be depending upon the circumstances. A point for the consideration is, whether a doctor is contractually guarantees the outcome of the treatment. Hence a patient might be able to bring an action when the treatment does not effect cure or produce the intended result¹¹⁵. It is pointed out that a doctor may enter into a contractual guarantee, but in order to do so, he must use explicit and unequivocal words such as “I guarantee you will be cared; I will assure 100% success etc,” In the absence of words of this nature forming part of the contract, the courts will not construe contractual terms as amounting to a guarantee of success¹¹⁶.

In the American case of *Guilmet Vs Campbell*¹¹⁷ the doctor treated the plaintiff for a bleeding ulcer. However, prior to the operation, the doctor told the patient: “once you have an operation it takes care of all your troubles, you can eat as you want to, you can drink as you want to, you can do as you please... there is nothing to it at all – it’s a very simple operation”. After the operation you can throw you pill box¹¹⁸. But, the plaintiff suffers severe physical injury after the operation. The court directs the defendant to pay compensation for the breach of contractual guarantee by observing that there must be sufficient evidence to show that the doctor has made a specific, clear and express promise to care or effects a specific result which was relied upon by the plaintiff.

¹¹⁴ Dugadale and Stanton, Professional Negligence, (3rd ed. 1998) Butterworths, para 16-20.

¹¹⁵ Kennedy Ian and Grubb Andrew, Principles of Medical Law, Oxford University Press p. 288.

¹¹⁶ Ibid.

¹¹⁷ (1971) 188 New 2d 601 (Mich SC)

¹¹⁸ Ibid p 606.

The leading English decision concerned with a guarantee of care or an effect is *Thake vs. Maurice*¹¹⁹ where the defendant agreed to perform a vasectomy on the first plaintiff. Before conducting operation, the defendant explained to the plaintiffs a married couple as to the nature of operation and its effects and he also pointed out that although it was possible to the husband's fertility he could not guarantee it and that the plaintiff should regard the operation renders him permanent sterile and irreversible. Subsequently around 3 years later the first plaintiff became fertile and the second plaintiff conceived and gave birth to a child. The couple moved a litigation claiming damages for the breach of contract, collateral warranty, misrepresentation and breach of contractual duty of care. The issue was, whether the defendant had promised that the vasectomy operation would achieve its purpose of making the first plaintiff permanently sterile. By majority it was held that the defendant was not liable as he had not given contractual warranty of success. The defendant had failed to give usual warning that there was a slight risk that the first plaintiff might become fertile. As the medicine is not an exact science and results are unpredictable, a doctor cannot be objectively regarded as guaranteeing the success of any operation or treatment unless he says as much in clear and unequivocal terms¹²⁰.

5.3.6. Implied Warranty of success.

Again the similar question which arises is, does the contract imply a warranty of success of treatment in the absence of express term? In *Eyre vs. Measaday*¹²¹ like *Thake vs. Maurice*'s case, the defendant performed a sterilization operation on the plaintiff after clearly briefing about the nature and effects of procedure and emphasized that operation was irreversible. The plaintiff and her husband believed that the operation would render the plaintiff completely sterile. Later the plaintiff became pregnant as a result of which she filed a suit claiming damages on the ground that the defendant was in breach of a contractual term that she should be irreversibly sterile and a collateral warranty to the effect which induced her to enter into contract. The court dismissed the plaintiff's contention holding that where a doctor entered into a contract with a patient regarding the performance of any operation, law would imply into the contract between the doctor and the patient a term that the operation would be

¹¹⁹ (1986) QB 644; (1986) 1 All ER 479 (CA)

¹²⁰ Ibid at 638.

¹²¹ (1986) 1 All ER 488 per slade LJ pp. 488, 492-494.

carried out/done with reasonable care and skill, and not the warranty of success where the doctor had stated that the procedure would be irreversible, since no responsible medical practitioner intends to give such a warranty¹²². Thus, in the context of medical negligence, the important warranty that the law implies from the contract is, in the case of doctors, to exercise reasonable care and skill when diagnosing, treating and advising the patient and in the case of hospitals, to provide sufficient facilities and competent staff including medical men. The doctor will be held liable only for the breach of contract to exercise reasonable care and not warranting a particular outcome from the treatment.

5.3.7. Damages and Award of Compensation

Once the plaintiff has proved that breach of duty and has shown that damage has resulted from that breach, the court will proceed with examining the award of damages. However, not every type of loss and expense will be recoverable. If the court arrives at the conclusion that the risk of damage which has occurred was too remote and it can not reasonably foreseeable, such damages are not recoverable. The assessment of damages is based upon the principles and methods of calculation evolved in the laws of contract and tort. However, there is vital difference in the principles applied to the assessment of damages in actions for tortious or contractual liability.

5.3.7.1. Purpose of damages

The basic purpose is awarding compensation is to put the plaintiff in the position that he would have been if the tort or breach had not been occurred¹²³. He is entitled to be compensated for all of his losses in terms of payment of money. In contract the plaintiff is entitled to be restored to the position that he would have been in had the contract been performed. Granting of compensation for personal injury upon the establishment of liability of the defendant-medical practitioner/hospital, is neither punishment or nor reward. The principle or rationale on which damages are assessed is that they should not be treated as punishment for a wrong inflicted. It is held by the court of appeal in UK that the object of granting damages in tort or in

¹²² Ibid.

¹²³ Maclean Alasdair, Brief case on Medical Law, (2nd Edition 2004), Cavendish Publishing Limited p. 169.

contract is to indemnify the plaintiff so far as personal injury which he had suffered on account of negligence of the defendant¹²⁴. Nonetheless, assessing the financial value of loss is ultimately arbitrary and indeed no amount of money can restore a lost limb or take away the plaintiff's experience of pain and suffering.

5.3.7.2. Types of damages

In a case for personal injuries, damages are divided into two categories:

- i) Special damages and
- ii) General damages

Where inexact or unliquidated losses are compensated by an award of damages what is known as 'general damages.' This includes the non-pecuniary losses which are compensated under the heads of pain and suffering¹²⁵, loss amenity¹²⁶, future losses of income or profits¹²⁷ and future expenses such as care and accommodation. Whereas, 'Special damages' are those losses and expenses that have actually been incurred and which can be calculated with reasonable precision at the date of trial, they normally comprises specific losses of income such as loss of earnings or profits which arise as a result of the plaintiff being unable to work because of the injury¹²⁸ and also specific expenses that have been incurred because of the tort or breach such as medical expenses¹²⁹, travel expenses, the cost of nursing care and attention¹³⁰. It has been suggested that classification of damages are important for pleading and procedural purposes and for the purpose of determining the appropriate rate of interest only.

¹²⁴ Wells vs. Wells (1999) AC 345.

¹²⁵ In *Ballantine vs Newalls Company Limited* (2001)1 ICR 25, it was held that a person who suffers mental anguish can recover compensation. Similarly, a person who is physically or mentally incapacitated by his injuries is entitled to be compensated for the anguish (*H West vs Shephard* (1964) AC 326).

¹²⁶ In assessing damage for the loss of amenities, the court generally take into the consideration: dependence of the injured on the help of other in his daily life (*Heaps vs Perrite Limited* (1937)2 All ER 60), the inability to lookafter (*Rourke vs Bouton*, *The Times*, 23rd June 1982), sexual impotency (*Cook vs JL Kier* (1970)1 WLR 774), inability to lead life which injured used to lead (*Owen vs Sykes* (1936)1 KB 192) and loss of prospects of marriage (*Harris vs Harris* (1973)1 Llyod's Rep 445).

¹²⁷ In *Nutbrown vs Sheffield Health Authroity* (1993)4 Med. LR 187, the court awarded damaged on basis of the age and future prospects of the plaintiff.

¹²⁸ In *British Transport Commission vs Gourley* (1956) A.C. 185, it was viewed that the injured claimant is entitled to recover damages in respect of loss of wages, salaries and fees as result of incident.

¹²⁹ In *Cutter vs Vauxhall Motors Limited* (1971)1 QB 418, it was observed that the plaintiff was entitled to recover his medical and other expenses such as traveling costs, accommodation charges etc.,

¹³⁰ *Rialas vs Mitchell*, *The Times*, July 17, 1984, the court held that medical and other expenses is part of the special damages.

iii) Aggravated and exemplary damages: Often a question which arises in the issue of medical negligence is, whether the court can award aggravated and exemplary damages for the injuries caused by the doctor's conduct. Where the conduct of the defendant is so outrageous and motivated by malice, additional compensation of what is known as aggravated damages can be awarded¹³¹. But in *Kralj Vs Mc Grath*¹³² the court indicated its reluctance to include an element of punitive damages in awarding damages to the injure-plaintiff and rejected the plaintiff's claim for aggravated damages as horrific and totally unacceptable. In the case of *Barbara Vs Home Offices* wherein the plaintiff who was forcibly injected by the defendant claims aggravated and exemplary damages for trespass to the person. The court granted aggravated damages by rejecting the claim for exemplary damages on the ground that mere neglect act does not give rise to such a remedy even if the victim treats it as oppressive¹³³.

5.3.8. Remedies for breach of confidence:

5.3.8.1. Injunction

Besides damages, the relief of injunction can also be granted in cases where the health professional makes unauthorized disclosure of confidential information. It is immaterial or irrelevant to consider whether the parties relationship is in contract or in tort (i.e. whether the plaintiff is a private patient or government hospital patient), what is required is that the person who possess the confidential information must be under an obligation to maintain that confidence. This remedy is available in a situation where the plaintiff has reason to believe that the doctor is about to make an unauthorized disclosure of confidential information. Then he is entitled to an interim injunction restraining the disclosure. In case the breach of confidence has already taken place, granting of injunction will not serve any purpose¹³⁴. Because, the most obvious reason for obtaining an injunction is to prevent a breach of confidence taking place. The question is how does the plaintiff know that the defendant is about to breach of confidence? Would there be any warning? Does the injunction not require for a past breach? It should be noted that where the confidence has already been

¹³¹ Mc Gregor, *Damages* (15th edition 1988) Sweet and Maxwell, p.1029.

¹³² (1986) 1 All ER 54. Lord Woolf J. observed "in my view it would be inappropriate to introduce into claims of this sort, for breach of tort or negligence, the concept of aggravated damages".

¹³³ (1984) 134 NLJ 888.

¹³⁴ *W vs. Egdell* (1989) 1 All ER 1089.

breached, then the person to whom the confidence is owed may still be entitled to an injunction as to prevent the defendant from continuing to disclose the information or disclosing further information.

5.3.8.2. Requirements:

Before granting an injunction, the court has to be satisfied with the three conditions such as a) the prima facie case b) irreparable loss or the loss which cannot be compensated in terms of pecuniary value and c) the balance of convenience in favor of the applicant. Additionally, the court may also consider social and economic factors and the relative strength of the respective parties' cases. The relief cannot be claimed as a matter of right as the granting or refusal is a discretionary of the court¹³⁵.

5.3.9. Award of Damages by Civil Courts in India:

5.3.9.1. Symbolic damages for death:

In *Ram Biharilal vs. JN Srivastava*¹³⁶ a patient who was the mother of seven minor children, diagnosed by the doctor as a case of acute appendicitis. The doctor did not do preliminary investigations like blood test, urine test etc, before subjecting the patient for operation. The help of anesthetist was also not obtained. Without taking preventive steps to counter adverse effect of treatment and without the consent of the patient, the surgeon removed the gall bladder. The negligence of the surgeon in using chloroform anaesthesia damaged the kidney and liver, resulting in death of the patient. The court awarded Rs. 3000/- for the plaintiff for the loss of service of his deceased wife, another Rs.1000/- for mental agony and physical suffering. The court granted these symbolic damages as pleaded by the plaintiff in the pleadings although the court had the power to grant damages more than what has been prayed in the pleading. This case reflects that the victim of medical negligence wants to prove the negligence of the surgeon rather than claiming damages as substitute for death. It is wrong to presume that the victims of negligence approach the court of law with the sole motive of harassing the practitioner for monetary benefits.

¹³⁵ American Cyanamid vs. Ethicon (1975) AC 396.

¹³⁶ 1985 ACJ 424.

5.3.9.2. Failure to perform emergency operation on the pretext of consent:

In the case of *Dr. T.T. Thomas vs. Elisa*¹³⁷ the plaintiff's husband was suffering from severe abdominal pain and pain had been diagnosed as a case of acute appendicitis, but the surgeon delayed in performing operation for two days on the ground that the patient refused the consent for treatment. The patient died due to perforated appendicitis. The court awarded a decree against the defendant for a sum of Rs. 37,000/- and ruled that the burden is on the surgeon to prove that non performance of the surgery or non administration of the treatment was on account of the refusal of the patient to give consent thereto. A surgeon, who fails to perform an emergency operation, must prove with satisfactory evidence that the patient refused to undergo the operation, not only at the initial stage but even after he was informed of the dangerous consequences of not undergoing the operation.

5.3.9.3. Death during tubectomy operation in Government hospital:

The *Rajmal Vs. State of Rajasthan*¹³⁸ the plaintiff's wife died while she was being operated for laparoscopic tubectomy at primary health center. The hospital did not have compulsory medical equipments such as endotracheal anaesthesia, defibrillator and cardiac monitoring equipments side providing necessary trained staff. The court held the state of Rajasthan vicariously liable to pay Rs.1,00,000/- by way of compensation to the plaintiff along with the 12% p.a. from the due date to till the actual date of payment. The amount of Rs. 10,000/- which was paid by the collector on the spot. as interim relief excluded from the amount of compensation.

5.3.9.4. Death of a woman following P.P.S. operation

A woman aged about 24 years was admitted into hospital for post partum sterilization operation after her delivery. She died on account of negligence of the doctor in performing the PPS operation. She was survived by her husband and three various children including a baby of two months old. The high court awarded compensation of Rs.1,60,000/- to the legal heirs together with interest at the rate of 12% p.a. from the date of institution of the suit till realization of the amount. Another a sum of Rs.1,00,000/- was considered as reasonable compensation under different

¹³⁷ AIR 1987 Ker 52; 1987 (1) ACJ 192.

¹³⁸ (1996) ACJ, 1966.

heads like loss of consortium, pecuniary loss, loss of amenities of life and shortened expectation of life¹³⁹.

5.3.9.5. Pain and suffering due to foreign body in abdomen:

In *Shanta Vs. State of Andhra Pradesh*¹⁴⁰ the patient who underwent caesarian operation in a government hospital developed pain and other complications after the operation. The testing report disclosed that foreign body (mop) was left in para spinal region the course of operation. By operation the foreign body was removed but required another operation for complete recovery. The High Court which invoked its jurisdiction under article 226 of the constitution directed the state to pay compensation of Rs.3,00,000/- to the petitioner for negligent treatment given by the doctors in a Government Hospital.

The above discussion on the accountability of health professionals under the law of contract shows that a patient or his legal heir is entitled to sue the doctor and/or hospital whether of private or government, for the loss occasioned by them due to their negligent acts. A review of cases decided by the courts also reveals that the scope and ambit of the liability of professionals has been widened considerably enabling the patient to take recourse to the civil court seeking appropriate damages. The burden of proof lies on the plaintiff to establish the factum of malpractice that comprises the duty of care, breach of such duty and the consequential damage. Strong and cogent evidence is needed without which the litigation will not be sustainable. The plaintiff must produce the medical records, documents, parties witnesses and medical expert opinions, whereas the defendant – doctor has no need to adduce evidence. The law of tort does not draw distinction between doctors serving in the private hospitals and government hospitals. The provisions of the law of contract are wide enough to cover even non-fulfillment of contractual obligation give rises the right cause of action for negligence. However it is vary difficult to prove the charge of malpractice, beside time consuming, cost of litigation. After the emergence of the consumer protection act, 1986, the consumer can seek remedy by filing a simple complaint against the professional for monetary compensation in the consumer forum.

¹³⁹ Joseph @ Pappachan vs. Dr. George Moonjely 1995 (1) ACJ 253.

¹⁴⁰ (1997) III CPJ 481, (HC of AP)

Therefore, it is appropriate to examine the accountability of the medical professional under the Consumer Protection Act 1986.

5.4. ACCOUNTABILITY OF HEALTH CARER AND CONSUMER PROTECTION ACT 1986

5.4.1. The Consumer Protection Act 1986: Outlines

The Consumer Protection Act 1986 has been enacted with very laudable and ambitious objects to promote and protect the rights of the consumers¹⁴¹. It is not the ‘new born baby’ of the legislature but only a “shorthand term to indicate the different aspects of general law”¹⁴². It aims to see that the aggrieved or injured consumer should not be left without any remedy and at the same time provides a speed and inexpensive remedy through quasi judicial bodies – District forum, State Commission and National Commission. These bodies will perform functions as custodian or watchdog of the rights of the consumers¹⁴³. They are like additional judicial schemes to offer the socially weaker section, an efficient means of access to the law where the regular court system fails to perform adequately¹⁴⁴.

It is also pertinent to note that the provisions of the Act are in addition to and not in derogation of the provisions of other law in force. The Act provides certain rights to the consumers as follows:

- a) The right to be protected against marketing of goods which are hazardous to life and property;
- b) The right to get information about the quality, price of goods, services, standard etc, to provide protection against unfair trade practice;
- c) The right to access to variety of goods/services at competitive price;
- d) The right to approach appropriate forum to protect his interest;
- e) The right to seek redressal against unfair trade practices or exploitation of consumers and
- f) Right to consumer education¹⁴⁵.

¹⁴¹ Rajendra Prasad A, the Consumer Protection Act, 1986- A Critical Appraisal, AIR 1989; Journal p. 12.

¹⁴² Rajendra Prasad A, Consumer Law and the Rule of Locus standi, SCJ, 1990 p. 39.

¹⁴³ Ibid.

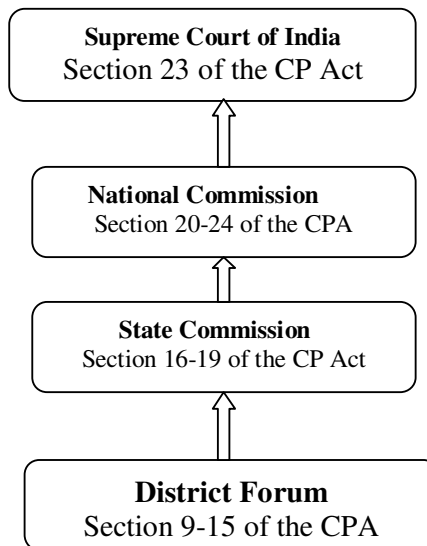
¹⁴⁴ Mercel Storme and Bernadatte Demenlencer “Innovations in the judicial and extra judicial resolution of consumer disputes in Belgium” 36 Am. J. Comp. L. (1988), p. 218.

¹⁴⁵ Moolchand, Consumer Protection Legislation – A Goal of Economic Justice, SCJ 1992, p. 63.

5.4.2. Justice delivery of system

The act provides for three tier consumer disputes redressal machinery to be set up at the national, state and district levels which provides inexpensive and speedy redress for consumer disputes against defective goods, deficiency in services, unfair trade practice and restrictive trade practices or a matter of charging excessive prices etc. The hierarchy of the consumer forum may be shown as under:

Consumer Disputes Redressal Agencies



5.4.3. Jurisdiction and procedure for disposal of complaints

The District forum shall have jurisdiction to entertain complaints where the value of goods or services and amount of compensation if any, does not exceed Rs.20 lakhs¹⁴⁶, the State Commission shall have jurisdiction to try complaints where the value of service and compensation claimed exceeds Rs.20 lakhs but less than Rs.100 lakhs¹⁴⁷ and National Commission shall have jurisdiction to hear original complaint if the value is Rs. 100 lakhs or more¹⁴⁸. The complaint shall be lodged before the consumer forum within the local limit of whose jurisdiction the opposite party at the time of the institution of the complaint, actually and voluntarily resides or carries on business or has a branch office or personally works for gain; or the cause of action arises¹⁴⁹.

¹⁴⁶ Section 11 (c) of the Consumer Protection (Amendment) Act 2002.

¹⁴⁷ Section 17 (1) of the Consumer Protection (Amendment) Act 2002.

¹⁴⁸ Section 21 (a)(i) of the CPA Amendment Act 2002.

¹⁴⁹ See section 4 (1) of the CPA 1986.

The prescribed (nominal) fees shall be payable along with every complaint filed¹⁵⁰, earlier, no fees was payable. It was therefore, argued that highly inflated and even bogus claims were filed just because no fee was payable. This tendency is reduced now. In case of appeal, some minimum amount is to be deposited otherwise, appeal will not be entertained¹⁵¹. Consumer disputes shall be decided within 3 months from the date of receipt of reply from the opposite party, or 5 months where the complaint requires laboratory test. The procedure filing complaint is simple. It can be filed by the complainant or his agent in person, or it can be sent by most of through email. The CPA contains the procedure for filing appeal. As against the decision of District Forum an appeal may be filed to the State Commission within thirty days. Against the decision of the State Commission the appeal shall be preferred to the National Commission within 30 days. Appeal against the decision of the National Commission shall be made to the Supreme Court within 30 days¹⁵².

5.4.4. Issues

1. Whether a patient can be considered as a consumer within the purpose of the Consumer Protection Act?
2. Whether the services rendered by a doctor are within the definition of service.
3. Does the negligence of the doctor constitute deficiency in service?
4. What is the extent of the liability of the medical practitioner under the Consumer Protection Act?

5.4.5. Patient as consumer

In order to comply with the definition of ‘consumer,’ a person should have hired or availed of any services for a consideration. The element of consideration serves as a test to determine whether a patient is a consumer or not. Although the question of consideration constitutes an important criterion, nowhere in the Act, the term has been defined. The absence of definition give rises an occasion to argue whether or not the consideration so vital for invoking the jurisdiction of the consumer forum. The literal interpretation of the definition shows that a person who wants to fall within the definition must satisfy three conditions.

¹⁵⁰ Section 12 (2) of the CPA 1986.

¹⁵¹ Section 18 and 22, will apply to state and national commission also.

¹⁵² Section 27A (1), (2) and (3) of the Act.

- A) The service must be hired by him;
- B) The service should have been rendered to him;
- C) For hiring service, he must have paid or promised to pay consideration ¹⁵³.

If services are rendered free of charge, it can not be hire. If a patient gets free medical treatment in a governmental hospital or in any charitable hospital, without payment, is not a 'consumer.' On the other hand if he obtains services or avails of medical facilities on payment basis in a private hospital or nursing home or clinic whether run by the Government or charitable institute, he is a 'consumer,' and therefore can invoke remedies provided in the Act by lodging a complaint before the appropriate forum¹⁵⁴. In Dr. A.S. Chandra vs. Union of India, a Division Bench of the High Court held that the persons availing of medical services for consideration in private practitioners, private hospitals and nursing homes are 'consumers'¹⁵⁵. However, a Division Bench of the Madras High Court has taken a different view in Dr. Subramanian vs. Kumaraswamy where it had been held that the services rendered to a patient by a medical practitioner or by a hospital by way of diagnosis and treatment, both medicinal and surgical, cannot be considered to be a 'consumer' within the meaning of Section 2(1)(d) of the Act¹⁵⁶.

In Consumer Unity & Trust Society, Jaipur Vs. State of Rajasthan the appeal was filed by the society against the decision of the State Commission, Rajasthan which held that as no consideration for services in the performances of the operation and treatment rendered by the Government doctor was paid or promised by the claimant, the complaint was not maintainable. The National Commission while dismissing the appeal and affirming the ruling of the State Commission observed as "... persons who avails themselves of the facilities of medical treatment in Government Hospital are not consumers and the said facility offered in Government hospitals cannot be regarded as hired for consideration."¹⁵⁷

¹⁵³ Dr. Baidyanath Chaudhary, Medical Negligence- Tortious liability and the recent trends in India, CILI 2002, Vol. XV, p. 149)

¹⁵⁴ Sudharani Srivastava, Consumer Protection and Medical Profession, AIR 1995, Journal p. 155.

¹⁵⁵ (1992) 1 Andhra Law Time 713.

¹⁵⁶ (1994) 1 Med LJ 438.

¹⁵⁷ (1991)1 CPR 241 (NC).

The State Commission of Delhi,¹⁵⁸ Karnataka,¹⁵⁹ Rajasthan,¹⁶⁰ Punjab¹⁶¹, Haryana,¹⁶² Kerala,¹⁶³ Maharashtra,¹⁶⁴ and Tamil Nadu,¹⁶⁵ observed that a person who avails himself of the facility of medical treatment in the Government hospital is not a 'consumer'; because the medical facility available in the government hospital cannot be regarded as service hired for consideration. On the other hand, the State Commission of Orissa¹⁶⁶ held that services rendered by doctors free of charge in government hospitals are within the scope of scrutiny by the Consumer Forum in as much as the doctors are remunerated for rendering service in the hospital. The view expressed by the State Commission of Orissa is no longer good law, because the issue has already been categorically settled by the National Commission in Consumer Unity and Trust Society's case. Now it is well settled by the decision of the Supreme Court which stated that any hospital where the patient pays charges for treatment is a consumer¹⁶⁷.

5.4.6. Medical Service

One of the most debatable points ever since the patient being considered as consumer is, whether services rendered by a medical practitioner, hospital or nursing home are services within the ambit of the definition of service under section 2(1)(i) of the Act. It is indeed a tussle between the medical body and consumer activists over the issue of inclusion or exclusion of the medical service from the CP Act. The expression 'service' has been defined as meaning "service of any description which is made available to potential users." The definition excludes two categories of services from the purview of the Act, namely (a) service rendered under a contract of personal service and service rendered free of charge. Placing strong reliance of the exceptional clause, it is pointed out that the service rendered by hospitals and member of medical profession for consideration will not constitute 'service' because service of a doctor renders under the contract of 'personal service,' and it is dependent on the personal

¹⁵⁸ Premchand Sharma vs. The Director, Central Government Health Scheme, 1992 (2) CRR 51(Del).

¹⁵⁹ Sowbhagya Prasad vs. State of Karnataka 1 (1994) CPJ 402.

¹⁶⁰ Hanuman Prasad Darban vs. Dr. C.S. Sharma (1991 (1) CPR 63 (Raj).

¹⁶¹ Pavitar Singh vs. State of Punjab (1994) 1 CPJ 394 (Punj)

¹⁶² Birbal Singh vs. ESI Corporation II (1993) CPJ (1028).

¹⁶³ Mrs Mable Roosevelt vs. St. of Kerala 1991 (1) CPR 330 (NC).

¹⁶⁴ Laxman Thamappa Kotgiri vs. UOI 1992 CCJ 1093 (Bom)

¹⁶⁵ Mappooyan vs. Dr. Premavati Elanto 1991(2) CPR 149 (Mad)

¹⁶⁶ Govind Chandra Mohanty vs. Director, Medical & Health Services II (1992) CPJ 89 (Ori)

¹⁶⁷ Indian Medical Association vs. V.P. Shanta 9NR 1996 SC 550.

service of a doctor, hence not amenable within the scope and consideration of the Act¹⁶⁸. Further, it is argued that members of medical profession are covered by the Indian Medical Council Act 1956 which provides a complete “code of conduct” and the said Act has not been superseded by the CPA, thus, the provisions of the latter cannot have any application to the members of the medical profession. The expression ‘consumer,’ ‘service,’ ‘hires any service,’ ‘consumer disputes,’ ‘defect’ and deficiency have to be understood in a commercial sense only. The CPA has no application to the medical profession at all or to the services rendered in hospital whether they are run by the government or private agencies and it is wholly incorrect to say that the medical service is a service under Section 2(1) (o) and a patient is a consumer.

5.4.6.1. Contract of service and contract for service

However, the National Commission in *M/s. Cosmopolitan Hospitals and Another Vs. Vasantha P. Nair*¹⁶⁹, rejected the above contention by holding that while a medical officer’s service may be called personal in the loose sense, it will be incorrect, infelicitous and even crude to call the professional or technical services as personal service. A contract of personal service stems from a master and servant relationship which is totally different from a medical doctor-patient relationship. The reason for excluding the rendering of service “under a contract of personal service” from the definition of ‘service’ under the Act is obvious. Such a servant or employee can be dismissed from the service by the master at will and therefore no occasion arises for the master to complain about the deficiency in rendering service by the employee. Providing medical assistance for payment by hospital and members of the medical profession falls within the scope of the expression ‘service’ as defined in the CPA and in the event of any deficiency in the performance of such service the aggrieved party can invoke the remedies provided under the Act by filing a complaint before the consumer forum having jurisdiction.

¹⁶⁸ B. Shekar Hedge vs. Dr. Sudharshan Bhattacharya & another, (Dr. Neeraj Nagpal, Compendium of CPA Medical judgment (1st edition 1996) Vol. 1, p. 93); Consumer Education and Research Society vs. Dr. Ratila B. Patel (Ibid), the State Commission of Gujarat has taken the view that the surgeon and the Anaesthetist having been rendering “personal service,” Commission has no jurisdiction to entertain any complaint against the category of such persons.

¹⁶⁹ (1992)1 CPJ 302 (NC)

The decision of the National Commission is based on the distinction between a) contract for service and contract of service. In the latter case, the master commands or requires what is to be done while in the other case, in addition to command what is to be done, he commands how it shall be done¹⁷⁰. It implies relationship of master and servant and involves an obligation to obey order in the work to be performed and as to its mode and manner of performance. In a contract to render service, one party undertakes to render services e.g. professional or technical services for another in the performance of which he is not subject to detailed direction and control but exercises professional or technical skill and uses his own knowledge and discretion¹⁷¹.

5.4.6.2. Service rendered free of charge and service rendered for consideration

In *Consumer Unity and Trust Society, Jaipur Vs. State of Rajasthan and others*¹⁷², one of the preliminary issues which attracted the attention of National Commission was, whether the complaint filed under the CP Act against the government hospitals and doctor maintainable? In other word, whether the medical services provided by the Government hospitals free of charge are services? It was argued that the medical services offered by the government hospitals and doctors should not be considered as services provided free of charge, and excluded from the purview of the Act, because, the government hospitals are founded from the taxes paid by the tax payers and the payment of taxes constitutes valid consideration to satisfy the requirement of the definition that the service must have been hired for consideration and the person who actually avails of the service of the Government hospital is in the position of the beneficiary of services which have been paid for by other tax payers. The National Commission while rejecting the appeal and upholding the judgment of the State Commission observed persons who avail themselves of the facility of medical treatment in Government hospitals are not ‘consumers’ and the said facility offered in government hospital cannot be regarded as ‘service hired consideration.’ There is a clear distinction between the payment of test and payment of fee. Those patients who occupy beds in paying words in government hospitals, they pay separate charges towards paying wards, since medical facilities available in

¹⁷⁰ A.C. Madagi vs. Crosswell Tailor and another (1991) II CPJ 586 (NC).

¹⁷¹ Dharangadh Mechanical Works Ltd vs. State of Maharashtra (1957 SC 267).

¹⁷² Supra note 157.

government hospital are common to all patients including those in the pay wards without discrimination, they are also not consumers.

The implication of the National Commission emerges as medical services are of two folds namely

- a) Services rendered by government hospitals, doctors, nursing home and dispensaries and
- b) Services rendered by private hospitals, practitioners and nursing homes.

5.4.6.3. Services rendered by government hospitals

The decision of the National Commission was vehemently criticized by the consumer activists who pointed out that in a socialist state, services are rendered by the state out of the resources collected from the people, if according to the constitution India is a socialist state, the people availing of services provided by the state be considered as services hiring for consideration and not the free of charge under the CP Act or else, it would be denial of the very foundation of the constitutional philosophy¹⁷³. The Commentator described the decision of the National Commission as “death knell of emerging consumer jurisprudence”. Notwithstanding the fact that the decision has been severally criticized, the final word on the applicability of the Consumer Protect Act is the services rendered by the hospitals and the doctors working in the government hospitals and dispensaries are outside the purview of the Act. It means if a patient approaches a government hospital and gets wrong treatment or sustain injury due to the negligence of the doctor, no complaint can be made, because service is provided free of charge.¹⁷⁴

5.4.6.4. Services rendered by private medical practitioners and hospitals

Where a doctor makes available his services to potential users for a consideration, the service will come under the purview of the Act; it is not a contract of personal service¹⁷⁵. In *Arvind Kumar Himatlal Shah Vs. Bombay Hospital Trust*¹⁷⁶ a complaint was lodged against the Hospital regarding carelessness and negligence

¹⁷³ Saraf D.N, Law of Consumer Protection in India, 1990 p.136.

¹⁷⁴ Sowbhagya Prasad vs. State of Karnataka (1994) (1) CPR 140) the State Commission dismissed complaint filed against the governmental and doctor on the ground that service rendered in the government hospital free of charge was not a service.

¹⁷⁵ 1992 (1) CPR 44.

¹⁷⁶ (1992) 11 CRR 155.

while treating a patient. It was alleged that after the operation, the wound was continually bleeding; no senior doctor attended upon him, as a result of continuance bleeding the patient had died. The Commission that accepted the complaint directed the opposition party to pay compensation for deficiency in rendering service. However, the question is whether the fee paid to a medical practitioner for operation includes post-operative care also? It has been held that “in fact fees paid to a medical practitioner for operation included post-operative care”¹⁷⁷.

It is now crystal clear that, according to the consumer forums, the services rendered by the private medical practitioners, hospitals and nursing homes are services within the meaning of the service under section 2(1)(o) of the Act and they are not services rendered under the contact of personal service but are services of professional nature.

5.4.6.5. The Scope of applicability of the Consumer Protection Act vis-à-vis health care provider: *Indian Medical Association Vs V.P Shanta*¹⁷⁸

For the applicability of CPA, National Commission has observed that the services rendered by the private health carer for consideration are services while the services rendered by the government hospital/nursing home, would not be services within the purview of the CPA. In this context, he patients may be classified into two groups,

- a) The patient of the government hospital
- b) The patient of the private hospital

This construction was challenged before the SC in the aforesaid case where the petitioners assailed the validity of the provisions of the Act so far as they are held to be applicable to the medical profession being violative of Article 14 and Article 19(1) (g) of the Constitution. The Hon’ble Supreme Court after a very thorough and exhaustive consideration laid down the following proposition of law in relation to the applicability of the CPA to the medical practitioners.

¹⁷⁷ B.S. Heggade vs. Sudhansu Bhattacharya (1993) 111 CPJ 388 (NC).

¹⁷⁸ AIR 1996 SC 550.

a. Service for consideration:

Service rendered to a patient by a medical practitioner (except where the doctor render service free of charge to every patient or under a contract of personal service) by way of consultation, diagnosis or treatment, with medicinal and surgical, would fall within the ambit of ‘service’ as defined in section 2(1) (o) of the Act.

b. Professional law does not exclude CPA:

The fact that medical practitioners belong to the medical profession and are subject to the disciplinary control of the Medical Council of India and/or State Medical Councils constituted under the provisions of the Indian Medical Council Act would not exclude the services rendered by them from the ambit of the Act.

c. Contract of personal service and contract for personal service: distinction

A ‘contact of personal service’ has to be distinguished from a ‘contract for personal service.’ In the absence of a relationship of Master and servant between the patient and medical practitioner, the service rendered by a medical practitioner to the patient cannot be regarded as service rendered under a ‘contract of personal service.’ Such service is service rendered under a ‘contract for personal service’ and is not covered by exclusionary clause of the definition of ‘service’ contained in section 2(1) (c) of the Act.

d. Contract of personal service:

The expression contract of personal service cannot be confined to contacts for employment of domestic servants only and the said expression would include the employment of a medical officer for the purpose of rendering medical service to the employer. The service rendered by a medical officer to his employer under the contract of employment would be outside the purview of ‘service’ as defined the section 2(1) (o) of the Act.

e. Service rendered free of charge:

Service rendered free of charge by a medical practitioner attached to a hospital nursing home where such services are rendered free of charge to everybody, would not be “service” as defined in section 2(1)(o) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing home would not alter the position.

f. Free service rendered at Non-government hospital:

Service rendered at a non-government hospital/nursing home where no charge whatsoever is made from any person availing the service and all patients (rich and poor) are given free service – is outside the purview of the expression ‘service’ as defined in section 2(1)(o) of the Act. The payment of a taken amount for registration purpose only at the hospital favoring home would not alter the position.

g. Service for charge at Non-government hospital:

Service rendered at a non-government hospital/nursing home where charges are required to be paid by the persons availing such services falls within the purview of the expression ‘service’ as defined in section 2(1) (o) of the Act.

h. Service rendered free of charge and for charge at Non-governmental hospital:

Service rendered at a non-government hospital/nursing home where charges are required to be paid by persons who are in a position to pay and persons who cannot afford to pay are rendered service free of charge would fall within the ambit of the expression ‘service’ as defined in section 2(1) (o) of the Act irrespective of the fact that the service is rendered free of charge to persons who are not in a position to pay for such services. Free service would also be “service” and the recipient a “consumer” under the Act.

i. Free service at Government hospital:

Service rendered at a Government hospital / health centre / dispensing where no charge whatsoever is made from any person availing the services and all patients (rich and poor) are given free service – is outside the purview of the expression ‘service’ as defined in section 2(1)(o) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing would not alter the position.

j. Free service and service for charges at Government hospital:

Service rendered at a government hospital/health centre/dispensary where services are rendered on payment of charges and also rendered free of charge to other persons availing such services would fall within the ambit of the expression ‘service’ as defined in section 2(1)(o) of the Act irrespective of the fact that the service is rendered free of charge to persons who do not pay for such service. Free service would also be “service” and the recipient a “consumer” under the Act.

k. Free service upon insurance policy:

Service rendered by a medical practitioner or hospital/nursing home cannot be regarded as service rendered free of charge, if the person availing the service has taken on insurance policy for medical care where under the charges for consultation, diagnosis and medical treatment are borne by the insurance company and such service would fall within the ambit of 'service' as defined in section 2(1) (o) of the Act.

l. Medical expenses met by employer:

Similarly, where, as a part of the conditions of service, the employer bears the expenses of medical treatment of an employee and his family members dependent on him, the service rendered to such an employee and his family members by a medical practitioner or a hospital or a hospital/nursing home would not be free charge and would constitute 'services' under section 2(1)(o) of the Act.

In view of the aforementioned, the Supreme Court upheld the judgment of National Commission rendered in *M/s. Cosmopolitan Hospital Vs. Vasantha P. Nair*¹⁷⁹ (supra) and *Dr. Louis Vs. Smt. Kannolil Pathoma*¹⁸⁰ wherein it was observed that the medical service rendered by hospitals and members of the medical profession falls within the scope of the expression 'service,' and dismissed the judgment passed in *C.S. Subramaniam vs. Kumaraswamy* and others¹⁸¹ wherein the High Court had held that the services rendered to a patient by a medical practitioner or a hospital by way of consultation, diagnosis and treatment cannot be considered to be a 'consumer.' Regarding writ petitions wherein the petitioners have sought a declaration that the provisions of the CP Act are not applicable to deficiency in medical service, and if the provisions are held to be applicable to medical professional and hospitals, same may be declared as unconstitutional as being violative of Article 14 and Article 19(1)(g) of the constitution. The Supreme Court held that the provisions of the Act are applicable to deficiency in service rendered by medical practitioners and hospitals.

¹⁷⁹ Supra note 169.

¹⁸⁰ Neeraj Nagpal, Compendium of CPA Medical Judgments, Neelam Prakashan 1996, p. 239.

¹⁸¹ Supra note 156.

5.4.6.6. Implications of the ruling

For the purpose of applicability of the Act, medical practitioners, government hospitals/nursing homes and private hospitals/nursing homes can be broadly classified into three categories:

- a) Where services are rendered free of charge to everybody availing the said services.
- b) Where charges are required to be paid by everyone availing the services and
- c) Where charges are required to be paid by persons availing services but some persons who cannot afford to pay are rendered service free of charges.

No difficulty exist in respect of first two categories, because, doctors and hospitals who render service without any charge whatsoever to every person availing service would not fall within the ambit of the 'service' u/s 2(1)(o) of the Act. So far as second category concerned, wherein the service is rendered on payment basis to all the persons, they would clearly fall within the ambit of section 2(1)(o) of the Act. The third category of doctors and hospitals do provide free service to some of the patients but the bulk of the service is rendered to the patients on payment basis.

So far as patients are concerned, the ruling implies/aims at classification of patients into (a) paying patients, (b) non-paying patients. The patients of the *first category* are consumers, in the event of any deficiency in the performance of medical service, the aggrieved party can invoke the remedies provided under the Act by filing a complaint before the consumer forum having jurisdiction to grant relief. Whereas, the patients of *second category* (except the patient of the third category of hospitals) are not consumers, for the obvious reason of availing services free of charge. It has been criticized that if a patient goes to a government hospital or charitable hospital or even a private hospital where no fee is charged and sustains injury due to the wrong treatment or negligence of the hospital/doctor no complaint can be made¹⁸². The consumer forum cannot entertain a complaint against the government hospital and the hospital which provides free service to the people. Does it mean where there is charity, there can be no negligence or no accountability for negligence under the CPA 1986, are the lives of crores of people who cannot afford expensive treatment at the

¹⁸² AIR 1992 Journal 151.

mercy of charitable or government hospitals or dispensaries have no meaning¹⁸³? The SC observation goes to show that a service is not a service if it is given free of cost. This is against the general notion that medical services are whether money is paid or not. All doctors, including those in government or charitable hospitals must be sued for compensation for injury caused by negligence. In the Law of Torts, the hospitals run by state are vicariously liable for the act of doctors, in the same way; hospitals should be made amenable to the consumer forum irrespective of the element consideration. It would be a violation of the right to life if law gives licence to doctors to indulge in negligence with no liability for injuries caused while discharging free services¹⁸⁴.

5.4.7. LIABILITY OF MEDICAL PRACTITIONERS AND HOSPITALS

5.4.7.1. Fundamental Principles

5.4.7.1.1. Proof of negligence sine qua non for the grant of remedy

It is the negligence in the performance of deficient service that is the foundation for the grant of the relief of compensation to a consumer for any loss or injury suffered by the consumer. The deficient in service should be established with the help of the expert evidence and other relevant documents. Once the negligence is proved, the opposite party is liable to the consumer – complainant for the loss suffered by him. If there is no negligence or negligence is not established with evidence, then the consumer forums have no jurisdiction to grant compensation¹⁸⁵. On the other hand, the deficiency in service is proved; the consumer forums shall grant any of the following relief¹⁸⁶.

- a) Return of the charges paid by the complainant;¹⁸⁷
- b) Payment of such amount as may be awarded as compensation to the consumer for any loss or injury suffered by the consumer due to the negligence of the opposite party;¹⁸⁸
- c) Removal of the defects or deficiency in the service in question¹⁸⁹;

¹⁸³ 1996 JILI, Vol. 3 P. 384.

¹⁸⁴ 1996 SCJ Vol. 1, p. 16.

¹⁸⁵ Gopal Raj R, 1 (1996) CPJ 143 (N.C); 1996 (1) CPR 60 (NC)

¹⁸⁶ Section 14 of the Act.

¹⁸⁷ Section 14 clause (c) CPA.

¹⁸⁸ Section 14 clause (d) of CPA.

¹⁸⁹ Section 14 clause (e) CPA.

5.4.7.1.2. Standard of care: Ordinary level of skill in the profession

As it has already been acknowledged in a series of cases, the standard of care required from a doctor is neither the very highest nor a very low degree of care but a reasonable degree of skill and knowledge is what the law requires¹⁹⁰. The test for determining the liability for deficiency in service is the test as applied in an action for damages for negligence¹⁹¹. The law does not require that a doctor in the discharge of his duty of care should use the highest degree of skill since it may not be acquired. It is enough for the doctor to show that he acted in accordance with the general and approval practice¹⁹².

5.4.7.2. Government doctor and hospital:**5.4.7.2.1. Liability of the hospital to refuse admission:**

A woman, who was entitled to medical assistance from the ESI hospital being card holder, approached the hospital as she complained of sudden pain in her abdomen. The attending doctor who examined her detected that the pain in the abdomen was acute. The hospital authorities, however, refused to admit her at the hospital on the ground of non availability of bed advised her to seek medical assistance from any other ESI hospital. Ultimately she was admitted in private nursing home where she died. It was argued that the complainant's wife cannot be treated to be consumer within the meaning of the CPA as they treated the patient at the earliest opportunity and that as no bed was available for admission, they advised her to seek admission in another ESI hospital. However, the State Commission held that the deceased was an employee of a factory which was registered under ESI scheme; she was covered by the definition of service under the CP Act. Denial of admission to the complainant's wife in spite of her precarious condition constitutes deficiency in service. A government hospital is meant for the amelioration of the suffering of a patient but in the instant case, ESI, hospital where the patient was complaining of acute pain in abdomen, did not show sympathy towards her. The opposite parties were liable to pay Rs. 2 lakhs as compensation to the complainant¹⁹³.

¹⁹⁰ (1993) 3 CPR 255.

¹⁹¹ See *Bolam vs. Friern Hospital Management Committee*, (1957), 1 WLR 582.

¹⁹² *Vinitha Ashok Vs. Lakshmi Hospital and others* (1992) (2) CPJ 372 (NC)

¹⁹³ *Ranjith Kumar Das vs. Medical Officer, ESI Hospital* (1998) (1) CPR 165.

5.4.7.2.2. Liability of the surgeon and hospital

A patient who was suffering from bilateral intracerebral aneurysms was taken to the hospital for treatment. During the time of operation when the skull was opened, it was found non-availability of drill procedure. As a result of which, the attending doctor abandoned and closed the operation without clipping of anaerysms. The patient was taken again for operation, after a week and anaerysm was clipped with clippers. The patient could not tolerate the stress and strain of the surgery done twice, and she died, however it was proved that the surgery was successful, and there was no negligence in the performance of the operation. The opposite parties raised preliminary objections about the non-applicability of the provisions of the CPA, on the ground that the hospital was run by the government rendering free service to the public. The commission held that free service would also be 'serviced and the recipient a 'consumer' under RAA.

5.4.7.2.3. Vicarious liability of the Government

In the case of *S.C. Mathur Brothers Vs. Ace India Institute of Medical Sciences and others*¹⁹⁴ the patient who had 90% lesions of the LCX, was admitted into the hospital for Angioplasty (plastic surgery of blood vessel) the complainant deposited Rs.60,000/- which was asked by the respondent hospital. The Angioplasty procedure led to development of blood clotting and ultimately death of the patient. It was alleged that the opposite party took 30 minutes to put heart and lung machine on the patient after cardiac arrest, had it been used on the patient within 3 or 4 minutes, the life of the patient could have been saved. In inordinate delay in not putting the patient on heart and lung medicine immediately after cardiac arrest manifestly demonstrates the medical negligence while treating the patient.

The objection raised by the opposite party is that the opposite party is neither a nursing home nor a hospital in the true sense but is a premier research centre in medical science established by the Act of parliament and totally funded by Central Government and the CPA is not applicable to the AIIMS, there is no relationship of consumer and the provider of medical service between the complainant and the OP/AIMMS, as no consideration was received or paid towards the operation and other treatments and charges were charged in connection with consumable, ward charges,

¹⁹⁴ (2006)3 CPJ 414.

administration expenses etc. The commission however, held that, the OP hospital is established by the Central Government, majority of patients hail from weaker, middle and upper class sections. Sometimes government officers including senior officials, Ministers and affluent section of the society also receive treatment because of the reputation of the doctors and the facilities. The OP has charged from the complainant for consumable, charges for ward etc, and the complainant also paid the fees, required. The payment of fees for the aforesaid purpose itself constitutes consideration, and the complainant a 'consumer.' However, the doctors of the government hospitals who receive monthly salary to treat patients cannot be held jointly or severally liable because that is no contractual relationship between the patient and the government doctors, but such relationship exists between the patient and the government hospital/dispensary or health centre, therefore the respondent/OP/AIIMS is liable for the negligence of its doctors.

5.4.7.2.4. Immunity of Government Doctors from the judicial scrutiny

5.4.7.2.4.1. Army doctors and hospital:

It was argued that the complainant's wife died on account of negligence in the treatment of his wife who suffered burn injuries. The opposite parties who are army officers employed in the Military hospital as doctors contended that their service was not service as they did not charges fee on the patient, the National Commission held that the complainant was not a consumer and the hospital where the deceased patient got treatment rendering service free of charge would not mean service within the meaning of clause (c) of section 2(1) of the Act. No consideration paid by the petitioner-complainant for the treatment rendered to his wife in the military hospital. Hence the CP Act is not applicable¹⁹⁵.

5.4.7.2.4.2. No action against Government doctor:

The patient was operated by a doctor in government service in a private nursing home run by him developed complications. The complainant lodged a complaint requesting departmental action against the doctor along with the

¹⁹⁵ B.C. Joshi vs. Dr. Sandeep Kumar & others (2002) 2 CPJ 125 where the state commission dismissed the complaint alleging negligence in treatment of a child in a government hospital free of charge; Smt. Vinod Kumari Srinivastava vs. Hindustan Aeronautics Ltd and another (1 (2003) CPJ 246), the State Commission observed that as no consideration is charged from patient for the medical services by the government dispensary, the complainant could not be a consumer in the CP Act.

compensation. The commission dismissed the complainant on the ground that action against the government doctor not within the jurisdiction of the consumer court and advised the complainant to seek remedy before a civil court¹⁹⁶.

5.4.7.2.4.3. Traditional and Conventional method:

It has been observed that while providing medical service treatment to a patient, if a doctor adheres to the traditional and conventional treatment and in spite of that treatment, the patient does not respond and even succumbs to ailment during or immediately after the operation, the doctor cannot be accused of negligence or deficiency in service. The commission did not find any legal infirmity in the case where the government doctor conducted the operation without the assistance of an Anaesthetist and after the completion of the operation the patient was transferred from the operation theatre to the general ward where the patient expired. The case occurred in the Civil Hospital, where the operation was successful but the patient died¹⁹⁷.

5.4.7.2.4.4. Service rendered free of charge:

Where the patient who availed of the medical service in the government hospital free of charge cannot claim compensation as there is no liability on the part of the government hospital. The commission refuses to entertain the complaint against the government for deficiency in service for the reason that the government hospital and the recipient of service does not fall within the purview of the Consumer Protection Act¹⁹⁸.

5.4.7.3. PRIVATE MEDICAL PRACTITIONER AND HOSPITAL

5.4.7.3.1. Ayurvedic Practitioner prescribing Allopathic medicine:

Where an Ayurvedic medical practitioner administered injection of allopathic medicines to the hand of the patient, without any evidence that he is entitled to prescribe or administer the injection of allopathic medicines, the doctor will be liable to the injured patient. The opposite party-doctor administered injection into artery instead of vein resulting in the formation of gangrene and amputation of three fingers.

¹⁹⁶ Pravin Sharma vs. State of Punjab, Dr. Thirtha Goyal, 11 (1997) CPJ 571.

¹⁹⁷ Savan Kumar vs. Dr. Surinder Katyal and 7 others; 1 (1999) CPJ 226.

¹⁹⁸ Shashikala vs. Command Hospital (Air Force) and Others (2005)2 CPJ.

The commission held the doctor guilty of negligence and directed him to pay compensation to the complainant¹⁹⁹.

5.4.7.3.2. Liability of Pharmacist for prescription of medicines:

In *Avtar Singh Vs. Dr. Swarn Prakash Garg*²⁰⁰ the opposite party prescribes to the complainant allopathic medicines by posing himself to be an MD in alternative medicine, although he has not studied any branch of medicine in the system of allopathic or in the system of alternative medicine recognized by the State Medical Council. The state commission while applying the principles laid down by the Supreme Court in *V.P. Shanta's* case held that the doctor is liable:

- i) For medical negligence for prescribing drugs for minimizing the chest pain;*
- ii) Has acted against the medical ethics; ii) was not qualified and authorized to practice in the allopathic system of medicine but he prescribed the allopathic drugs to the complainant patient; iv) lack expertise; v) was responsible for further deterioration of his condition aggravating chest pain; vi) was neither registered nor qualified; vii) is only a registered pharmacist having diploma in pharmacy and also a diploma in x-ray technology; viii) is guilty of negligence 'per se', for acting in contravention of the law²⁰¹.*

5.4.7.3.3. Baby suffers paralysis in conducting delivery

The State Commission while dealing with a complaint filed in *K. Raji Reddy Vs. Dr (Mrs) Aruna Reddy & Another*²⁰² where a newly born baby suffered paralysis due to the negligence on the part of the doctor while conducting the delivery, viewed that the “child not only suffers physically through out her life, but will also affect her career and matrimonial life, there being a permanent disability.” There was deficiency of service on the part of the opposite party while conducting delivery. The doctor failed to exercise due and reasonable care while discharging his duty, hence the respondent was held not only responsible for irreparable loss suffered by the complainant, but also liable to pay damages.

5.4.7.3.4. Sponge left in abdomen while performing ceasarian section:

In *Harvinder Kaur vs. Dr. Sushma Chawla & Another*²⁰³, after the delivery by ceasarean operation, the complainant got the tubectomy operation done from the

¹⁹⁹ *Kharitilal vs. Kewal Krishnan*, 1 (1998) CPJ 188 (CDRC Punjab).

²⁰⁰ (2000) 1 CPR 44.

²⁰¹ Section 15(2) and (3) of MCI 1956.

²⁰² (1996)1 CPR 244.

²⁰³ (2001)III CPJH 143.

opposite party. The opposite party advised the complainant to take rest in spite of complaining of consumer weakness and unbearable pain in the abdomen. The scanning report revealed some foreign object (sponge) in the abdomen. The 'sponge' was left at the time of stitching the internal layer and outerskin of the abdomen. Due to the negligent act the complainant spent money for medicine and second operation for removal of sponge, suffered physically as she was unable to do her routine jobs and incapacitated to look after her children. The commission found the opposite party as responsible for the suffering of the complainant²⁰⁴.

5.4.7.3.5. Joint Liability of hospital and surgeon

Where the surgeon while performing laparoscopic cholecystectomy, cut the bile duct in the body known as CBD which resulted in the bile collection in the stomach, which ordinarily was to go to the intestine for digestion of fats. Since CBD had been cut negligently, the patient was forced to go for bypass surgery in another hospital. It was argued for the opposite party that injury to the CBD in the performance of operation for removal of Gall Bladder is a common feature and cannot be attributed to the negligent act of the surgeon. The question is whether the surgeon is liable for the alleged negligent act in performing laparoscopy in the process of removal of Gall Bladder of the patient-complainant. The commission observed that only cystic duct was required to be cut not the CBD in the process of laparoscopic surgery. The surgeon was guilty of negligence, since the surgeon was employed by the hospital, both the surgeon and hospital are jointly and severally liable to pay the compensation to the patient²⁰⁵.

5.4.7.3.6. Liability of Hospital for the wrong medicine supplied by the pharmacy

In the case of *Deepak Gokaran Vs. Chaiman, Mahant Gurmukh Singh Charitable Hospital Trust and Another*²⁰⁶, the complainant's minor child was suffering from acute tonsillitis for which the attending doctors prescribed certain course of drugs. However, the hospital pharmacist who supplied different drugs, issued the bill with the same medicine prescribed by the attending doctors. The doctor

²⁰⁴ (2003) (1) CPJ 518)

²⁰⁵ Smt. Gurmit Mahal vs. Chauhan Nursing Home and Another (1998 CLT 399).

²⁰⁶ (2003)1 CPJ 518.

administered to the child- patient without ensuring that the medicine supplied was the same as prescribed. The complainant filed a complaint against the hospital and the doctor alleging negligence on their part in administering wrong drugs to the child. It was argued by the respondent- hospital the hospital cannot be held responsible for the supply of medicine other than one prescribed by the pharmacy located in the hospital premises. The Commission held that the hospital was liable for two reasons: (a) the pharmacy which has supplied medicine other than the one prescribed located in the premises of the opposite party hospital and it is a matter of common knowledge that in the hope of getting genuine medicine the patient or the persons looking after the patient usually approach the pharmacy because they have a belief that the medicine supply to them would be correct and genuine. (b) the chemist in the pharmacy should have explained to the complainant that the prescribed medicine was not available with him, and moreover, even if the pharmacy had supplied the medicine other than the prescribe done, it was the bounden duty of the doctors on duty to ensure the medicine administered to the patient was the prescribe done. Because of lapse on the part of the staff, the hospital cannot escape liability, and the commission directed that the hospital authorities shall pay compensation to the complainant for deficiency in service in treating the son of the complainant.

5.4.7.3.7. Vicarious liability

Smt. *Rekha Gupta Vs. Bombay Hospital Trust & Another*²⁰⁷ a patient of pulmonary tuberculosis undergoes kidney transplantation, thereafter the right forearm develops heavy swelling which is known as “compartmental compression gangrene” leading to his death. Denying the liability for the negligence of the surgeon, the hospital argues that the opposite party-hospital provides infrastructure facilities, services of nursing staff, supporting staff and technicians and it cannot suo motu perform or recommend any operation. The hospital pays fees collected from the patient to the consultant with deducting of 20% as commission and it has no direct control over the consultant, as such it cannot own the responsibility for the negligent of the consultant. The State Commission observed that the hospital is vicariously liable for any negligence on the part of the consultant²⁰⁸. In another case of A.M.

²⁰⁷ (2003) 2 CPJ 160 (NC).

²⁰⁸ *Neha Kumari and another vs. Appollo Hospital and others* 1 (2003) CPJ 145 (AC) where the commission held that the hospital would be liable for the negligent act of the consultant.

Mathew vs. the Director, Karuna Hospital and others²⁰⁹, where an eight year old boy was taken to hospital following fever and cold, the doctor prescribed an injection which was administered by the nurse immediately developed paralysis of left leg. The complainant demanded compensation on the doctrine evolved by the National Commission that the hospital is responsible for the acts of its employees and the hospital is liable for the consequence. The court held that minor child had suffered on account of negligence of the nurse who was an employee of the hospital. Hence the hospital is liable to pay damages to the complainant for the treatment expenditure and cost of proceedings.

5.4.7.4. Compensation for negligence

One of the remedies provided by the Consumer Protection Act is payment of money as compensation to the consumer for any loss or injury suffered by the consumer due to negligence of the opposite party²¹⁰. But the question is how to assess the amount of compensation and is there fixed criteria for determining the quantum of compensation remained conundrum without being the answer. In India unlike UK, each commission may follow its own procedures in awarding compensation for the negligence of the opposite party. The criterion varies from case to case. Where the complainant claims for the amount spent on bringing up the child and giving education to him, the commission has held that such contention is devoid of merit. The principles for determining compensation on account of negligence of doctors remain the same as in the law of torts.

5.4.7.5. Return of the charges

Another remedy available under the CP Act is return of the charges paid by the complainant (Clause (c) of Section 14). Where the doctor collects fee as consultation charges or professional charges without legal jurisdiction, the consumer forum may order the opposite party doctor to return whatever the fee he collected in rendering medical service. In C.R. Jose and another Vs. Mother Hospital (P) Ltd, the complainant was admitted to the opposite party hospital for operation. On the day of discharge the opposite party received from the complainant Rs.15,500 and 1000/- by way of professional charge and consultation fees. It was alleged that the hospital has

²⁰⁹ (1998) 1 CPR 39.

²¹⁰ See clause (a) of Section 14 of the CPAct).

charged fees twice for the same treatment and there was deficiency in service on the part of the opposite party. The opposite party is liable to return that amount on the ground that it was collected without any justification²¹¹.

The accountability of the medical professionals under the Consumer Protection Act 1986 is still debatable issue. The Act does not clearly state that health service is a “service” under section 2(1) and the patient is undoubtedly a “consumer” under Section 2(1) (d) of the Act 1986. The judicial interpretation rather than the intention of the legislature that excludes professionals or health carers from the scope of the Act 1986 such as, services rendered at the government hospitals/health centres / dispensaries on payment of mere nominal charges and free services to all patients (rich and poor). A patient who avails of free service either in the government hospital or charitable institution is not entitled for remedies under the CP Act. This rule raises the questions;

- a) Shouldn't there be liability of doctors or hospitals when the service rendered free of charge or at charity?
- b) What is the remedy to a patient who avails the service of the government doctor or hospital in case of medical negligence?

Neither the judicial interpretation nor the framers of the existing CP Act provides answer to these questions. On the other hand, that the medical professionals vehemently argues that professionals be exempted from the judicial scrutiny because, they are governed by the Indian Medical Council ct 1956 and are subject to the disciplinary control of Medical Council of India and State Medical Council. In view of this, forthcoming part explores the professional liability under the Medical Council Act 1956 and its allied laws.

5.4. ACCOUNTABILITY OF MEDICAL PRACTITIONERS THROUGH PROFESSIONAL SUPREME BODIES

Medical practitioner includes practitioner of allopathic, Ayurveda and Unani, Dental, Physiotherapy, etc, medicine. Each branch of medical system is regulated by its own legislative enactment, for e.g. Allopathic practitioners are governed by the

²¹¹ (2005)2 CPJ 679.

Indian Medical Council Act 1956, similarly, dentists are by the Dental Council Act 1948, Homeopathic practitioners are by the Homeopathic Central Council Act 1973. These statutes provide for the establishment of medical councils at the national and states levels and confer them the authority to regulate medical education, registration of doctors and behavior of the members through the formulation of code of medical ethics.

5.5.1. The Indian Medical Council Act 1956

In India owing to the prevalent ayurvedic and Unani systems, no medical act had been passed to control or restrict the medical practices. In 1916, the Government of India passed the Indian Medical Degrees Act to regulate the grant of titles implying qualification in Western Medical Science and to restrain the assumption and use by unqualified persons²¹². Within few years, the State Governments created medical councils in Maharashtra, Gujarat, Madras, Bihar, Punjab and few other states by passing the Medical Act for registration of medical practitioners and supervision of medical education in their own states. However, registration was not compulsory under different state medical council acts except Bombay Medical Practitioners Act, 1936²¹³.

In the year 1933, the Indian Legislative Assembly passed an Act to be known as the Indian Medical Council Act which was repealed by the present Act of 1956. The Act of 1956 provides for reconstitution of the Medical Council of India, the maintenance of a medical register for India and matters incidental thereto. The Act empowers the Central Government to constitute a medical council, the membership of which is inter-alia, of persons to be selected by the agencies specified in Section 3 of the Act and the manner specified therein. It empowers the Medical Council to grant recognition to medical degrees granted by universities or medical institutions in India and such other qualifications granted by medical institutions in foreign countries²¹⁴. The Council prescribes the minimum standards of medical education required for granting recognition to the degrees awarded by Universities in India²¹⁵, prescribes

²¹² Frankline CA, Modi's Medical Jurisprudence and Toxicology, (ed.) Tripathi (p) Ltd. 1988, p. 503.

²¹³ Ibid.

²¹⁴ Section 12 of IMCA 1956.

²¹⁵ Section 19A, IMCA 1956.

standards of professional conduct, etiquette and a code of ethics for medical practitioners²¹⁶ and prescribes eligibility requirements to be a medical practitioner²¹⁷.

5.5.1.1. Disciplinary Action

Medical councils have the disciplinary control over the medical practitioners. They have the power to remove the names of medical practitioners permanently or for a specific period from the medical registers when after due inquiry they are found to have been guilty of serious professional misconduct²¹⁸. There are two grounds on which the council may initiate disciplinary against any medical practitioner namely (a) conviction of any offence by a court of law and (b) guilty of professional misconduct. Any conduct of the practitioner which brings in disgraceful to the professional status what is known as “serious professional misconduct,” for e.g. adultery or improper conduct or association with a patient, conviction by a court of law for offences involving moral turpitude, issuing false certificates, reports and other documents; issuing certificate of efficiency in modern medicine to unqualified person or non-medical person; performing an abortion or illegal operation for which there is no medical, surgical or psychological indication; contravening the provisions of the Drugs Act and regulation made thereunder; using touts or agents for procuring patients; publication of identity of a patient without his permission; performing an operation which results in sterility, without obtaining the written consent of patient/relative and refusing on religious grounds alone to extend medical assistance etc. If any one is found guilty of offences mentioned in the warning notice issued by the appropriate medical council constitutes serious “professional misconduct”.

5.5.1.2. Judicial procedure:

Generally, the council by itself does not start proceedings. The proceedings are started: (i) when a medical practitioner has been convicted by a court of law, and (ii) on a complaint lodged by any person or body against the practitioner. On receipt of the complaint, the same will be placed before the sub-committee or the Executive Committee which considers the complaint, causes, further investigation and takes legal advise. If no prima facie case is made out the complainant is communicated

²¹⁶ Section 20A of IMCA 1956.

²¹⁷ Section 14, 15 and 16 of IMCA 1956.

²¹⁸ Narayana Reddy KS, Essentials of Forensic Medicine and Toxicology, (15th Ed) 1995, Suguna Devi Publication p.20.

accordingly. On contrary, a prima facie case is established, a notice is issued to the practitioner specifying the nature and particulars of the charge and directing him to answer the charge in writing and to appear before the committee on the appointed day. After the conclusion of the case, the issue put to the voting. If the majority vote confirms that the charge has been proved, the council must vote again and decide whether the name of the practitioner should be removed from the register or he should be warned, not to repeat the offence.²¹⁹

5.5.2. Dentists Act 1948

The Dentists Act 1948 provides for the establishment of the Dental Council the objective of which is to regulate dental education, the dental profession and dental ethics. The council has got the power to recommend the central government to grant permission to open new colleges or higher courses in the dentistry and fix the intake capacity of the dental colleges. The council prescribes the minimum standards of education and maintain the register of qualified dentists and erase the name of dentist after due inquiry into the alleged professional conduct²²⁰. Under the Act, no person other than a registered dentist, registered dental hygienist, shall practice dentistry or the art of healing or claiming or polishing teeth or of making or repairing dentures and dental appliances²²¹.

5.5.3. Indian Nursing Council Act, 1947

Similar to the Indian Medical Council Act 1956 and the Dental Council Act 1948, the Nursing Council Act which was enacted in 1947 provides for the constitution of the Nursing Council with the authority to regulate the nursing education and nursing registration. The State may have state legislation for the establishment of the state nursing council. The council grants recognition to the qualification accorded by the nursing institute. The council maintains a register of nurses, mid wives, auxiliary nurses mid wives and health visitors to be known as the Indian nurses register, which contains the names of all persons who are enrolled on any state register²²². The nursing council can inspect the nursing institutes and review their functions; it may also issue guidelines concerning the courses. However, the

²¹⁹ Ibid at page 21-22.

²²⁰ Section 17A of the Dentists Act.

²²¹ Section 49 of the Act.

²²² Section 14 of the Act.

lacunae of the Act is, the Act does not contain any provisions in respect of control unregistered nurses etc, code of ethics for the practitioners, and penal provisions to punish those who violate the Act²²³.

5.5.4. Indian Central Council Act 1970

The Indian Medicine Central Council was passed in 1970 with the prime objectives of regulating the practice of Indian system of medicine or non-western system of medicine i.e. Ayurveda, Siddha and Unani systems of medicine²²⁴. Prior to the Act 1970, there were no uniform standards for admission to and contents of curriculum of Indian medicine. The present Act provides for a single central council which regulates Indian Medicine education practice and ethics. The Council is empowered to prescribe necessary qualifications and grant of recognition to qualification granted by the institutes²²⁵ and remove names of practitioner from the Central Register of Indian Medicine for professional infamous behaviour²²⁶.

5.5.5. The Homeopathy²²⁷ Central Council Act 1973

The Homeopathy Central Council Act 1973 was enacted primarily to regulate the conduct of homeopathic practitioner in India. The Council is empowered, inter alia, to prescribe uniform minimum standards for admission, curriculum and syllabus and duration of course of training for homeopathy professionals. This Act like the Indian medicine Central Council Act 1970 provides for maintaining a central register by the Central Council²²⁸ and for regulating professional conduct of homeopathy professionals by formulation of a code of ethics²²⁹.

²²³ Varadappan Committee (1989), Report of the High Power Committee in Nursing and Nursing Profession, Ministry of Health and Family Welfare, New Delhi.

²²⁴ Section 2(c) of the I.C.C. Act of 1970 defines "Indian Medicine" as the system of Indian Medicine commonly known as ashtang, ayurveda, siddha or unani as the Central Government may declare by notification from time to time.

²²⁵ Section 16 and 17 of the Act.

²²⁶ Section 27 of the Act.

²²⁷ The term 'Homeopathy' is derived from two Greek words 'homois' which means like or of the same kind and 'pathos' means suffering. Homeopathy is an alternative system of medicine, based on the nature's law of care, namely 'like cures like.' The truth of the law was discovered by a German Scientist Dr. Samuel Hahnemann in 1796. Homeopathy differs considerably from other systems of medicine in diagnostic and treatment procedures. The procedure of homeopathy treatment is slow, but it is claimed to remove the disease/disorders from its roots (Employment News, New Delhi 6-12 April 2006).

²²⁸ Section 21, Homeopathy Central Council Act 1973.

²²⁹ Verma SK, Legal Framework for Health Care in India, p. 83.

5.5.6. Grievance Redressal Mechanisms

5.5.6.1. Mechanisms at the national level

As it has already been observed, the Government of India has enacted various legislations for the purpose of regulate medical professional education, practitioners and their code of conduct, viz, the Medical Council of India, 1956, the Dentist Act 1948, the Nursing Council 1947, Indian Medicine Central Council Act 1970, State Medical Council Acts. Any person who feels aggrieved by the act of the practitioner may lodge a complaint before the concerned medical council in which register, the practitioner has been enrolled as qualified professional. Beside this, the similar complaint can be referred to the Secretary, Ministry of Health and Family Welfare, with a request to take appropriate action against the concerned practitioner for contravening the code of ethics and the provisions of the statute. The Council and Ministry of Health and Family Welfare are empowered to regulate the conduct of health professionals.

5.5.6.2. Mechanism at the state level:

Under the state legislation, any aggrieved person can make a complaint to the State Council or to the secretary, Ministry of Health and Family Welfare. The disciplinary committee constituted by the State Council looks into the complaint and recommends the necessary action to be taken against the accused-practitioner. The Council in collaboration with the Secretary, Ministry of Health and Family Welfare may launch prosecution against those persons who are practicing medicine without possessing recognized medical qualifications.

5.5.6.3. Mechanism at the district level

Although a complaint can be filed before the Chief Medical Officer of the concerned district, it is always beneficial to approach the state council for legal action. It is the primary responsibility of the District Magistrate and Chief Medical Officer to trace and initiate criminal action against the quack medical practitioners²³⁰. However, there is lackadaisical attitude on the part of the chief medical officer in preventing unauthorized practitioners. It has become a common sight in the district where

²³⁰ D.K. Joshi vs. State of U.P. & others (2000) 5 SCC 80.

unqualified and unregistered medical practitioners are playing with the health and life of the innocent people²³¹.

5.5.6.4. Points for consideration

With the thorough examination of laws relating health practitioners/professionals, it is highly relevant to focus on the issues, namely:

- a) What is the remedy available to the complainant due to the negligent acts of the medical professionals?
- b) Whether the health professionals are immuned from the judicial scrutiny as professionals are subject to the disciplinary action of their respective council?
- c) Whether the practitioners of Indian traditional systems of medicine (AYUSH – Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy) can practice modern scientific system of medicine?
- d) Whether the medical associations have power to look into the cases of medical negligence of the doctor?

5.5.6.5. Remedy to the patient-complainant

One of the questions is, whether the medical council can grant compensation to the complainant upon the proof of negligence. This question came up for the consideration of the State Commission in Y. Meenakshi Vs. Dr. H. Nandeesh & another²³² wherein the complainant lodged a complaint to the Karnataka State Medical Council on the ground of negligence in treating him. The council which found the guilty of negligence awarded the nominal compensation. However, the complainant moved the consumer forum for compensation on the basis of findings of the medical council. The State Commission held that the State medical council has no jurisdiction to grant compensation to the complainant. It could only take action against respondent for his negligence by administering a warning or removing his name from the list of registered medical practitioner by canceling his registration. The finding of the Medical Council as regards the negligence of the respondent cannot be binding on the commission.

²³¹ Avtavr Singh vs. Dr. Swaran Prakash Garg (2000) 1 CPR 44, the State Commission directed the Secretary, Ministry of Health and Welfare and the Chief Medical Officer to take necessary action against quack practitioner.

²³² (1991) 2 CPJ 553.

5.6.7. Accountability of Medical professionals

It has been argued by the medical association in **V.P. Shantha's case** that the medical practitioner should be kept out of the purview of the Consumer Protection Act 1986, as there is scope for disciplinary action under the Medical Council Act for violating the code of medical ethics and for the breach of duty to exercise reasonable care and skill in rendering medical service to the patient. The Supreme Court held that, the medical practitioners are not immuned from a claim for damages for negligence. The fact that they are governed by the Medical council Act and are subject to the disciplinary control of the medical council is no solace to the person who has suffered due to their negligence and the right of such person to seek redress is not affected²³³.

5.5.8. Medical Association's jurisdiction of hear complaint:

In Heirs and LR's of the deceased *Arvind Kumar Himmatlal Shah Vs. Bombay Hospital Trust*²³⁴, wherein due to lack of postoperative care following operation of hip led to the death of a patient. The complainants wrote a letter to the Indian Medical Association, New Delhi about the carelessness and indifferent attitude of doctors and staff of hospital in treating the patient. Complainants were informed that the IMA has no statutory power and authority to look into such cases of negligence of doctor. The Association simply advised the complainants to forward the said complaint to the State Medical Council, stating that the medical council is only the competent authority to deal with such cases apart from the judicial authorities. Thus, no cognizance was taken by the medical organization, considering this point, the state commission held that it was deeply grieved to note the inaction on the part of these highest professional bodies meant for the observance of the professional conduct of the practicing doctors and the hospitals.

The provisions involved in the Indian Medical council Act reveal that the Council is empowered to inter alia, the Medical education and the conduct of members of the profession by requesting them to adhere to the code of medical ethics.

²³³ (1995) 6 SCC 651.

²³⁴ (1992) 2 CPR 154. It is the case of the complainants that after operation, the wound was continuously bleeding till the death of patient, no senior doctor attended him, relatives of the patient were not forewarned to keep sufficient stock of blood in the event of emergency, the doctor of their choice was not permitted to treat patient.

The code of ethics is a standard to measure the conduct/behavior of the practitioner. But the code is not enforceable in the court of law as it lacks the sanctioning authority. Whenever the code is violated by any professional, the aggrieved party will have to approach the central council or state council as the case may be. If the Central council is approached, generally, the council will not hear the complaint; instead, it will send the complaint for the concerned state medical council with a direction to take suitable action. By this procedure, what appears that the mechanism has been failed to discipline erred members of the profession. If the state is moved, there is likelihood of the council being influenced by the members of the profession and ultimately proceedings end with dismissal of the complaint. As against the ruling of the council, the aggrieved may approach the State government; virtually aggrieved party is left in lurch without accessible to justice.

Besides the thorough analysis of Medical Council Act and its allied law clearly points out certain lacunas, firstly, neither the Central Council nor the State Council is vested with power to take *suo-moto* action against those who violate the code of ethics, and law. Secondly, the council has no jurisdiction to grant compensation to the complainant who has suffered loss due to the negligent of the practitioner.

5.6. PROFESSIONALS LIABILITY UNDER THE INDIAN PENAL CODE

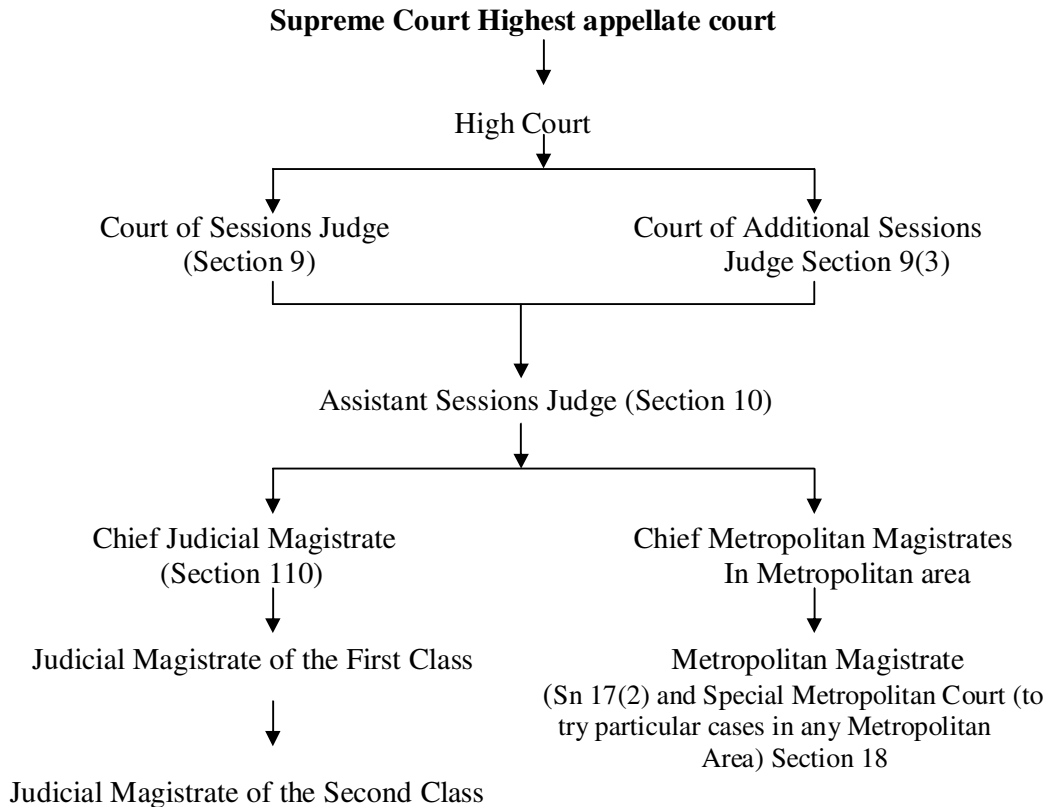
Under criminal law, the injured person or legal representative of victim of medical malpractice does not get remedy in terms of money or compensation. The main object of the law is not to award damages but to ensure that the doctor is put behind bars for his negligent act. However, under the Criminal Procedure Code, the court may award compensation to the aggrieved party out of the fine amount collected from accused²³⁵. In *Mari Singh and State of Haryana vs. Sukhbir Singh*²³⁶ the Supreme Court directed all criminal courts to exercise the power of awarding compensation to victims of offence in liberal way that the victims or their legal representatives may not have to rush to the civil courts for compensation. It may be argued that incidentally Indian Penal Code 1860 does not specify the crime of medical

²³⁵ Kar. L.J. 2006 (6) Journal p. 44. see Section 357 of Cr.P.C. 1973, empowers the criminal courts to award compensation to the victims along with judgment of connection.

²³⁶ 1988 SC 2127; 1989 Cr.L.J. 116 (SC)

negligence, nonetheless, negligent act of the doctor causing hurt, grievous hurt or death has been brought within the ambit of the provisions of Indian Penal Code. A doctor may be punished for causing death by rash and negligent act²³⁷, causing hurt by act endangering life or personal safety of others²³⁸ and causing grievous hurt by act endangering life or personal safety of others²³⁹.

5.6.1. Hierarchy of criminal courts²⁴⁰



5.6.2. Power of courts:

The Cr.P.C. enumerates the courts by which different offences can be tried, and then proceeds to define the limits of sentences which they can pass. These limits show the maximum sentence which a court can pass. The High Court can pass any sentence authorized by law²⁴¹, so also session’s judge or additional session’s judge may any sentence authorized by law; but any sentence of death passed by any such

²³⁷ Section 304-A of IPC.

²³⁸ Section 337 of IPC.

²³⁹ Section 338 of IPC.

²⁴⁰ See Section 6 of Cr.P.C.

²⁴¹ Section 28(1) of Cr.P.C.

judge is subject to confirmation by the High Court²⁴². An Assistant Sessions Judge may pass any sentence except death, life imprisonment or imprisonment exceeding ten years²⁴³.

The Court of Chief Judicial Magistrate has power to pass any sentence authorized by law except a sentence of death or of imprisonment for life or of imprisonment for a term exceeding 7 years. The courts of a Magistrate of the first class may pass a sentence of imprisonment for a term of not exceeding three years, or of fine not exceeding five thousand rupees or both²⁴⁴. The court of Magistrate of the second class may pass a sentence of imprisonment for a term not exceeding one year, or of fine not exceeding one thousand rupees, or both²⁴⁵. The court of Chief Metropolitan Magistrate shall have the powers of the court of a Chief Judge Magistrate and that of a Metropolitan Magistrate the powers of the court of a magistrate of the first class.

5.6.3. Prosecution of doctors: Procedure

In the case of death of a patient due to the rash or negligent act of the medical man, the legal representatives of the deceased may lodge information with the SHO of the police station for registration of the First Information Report (FIR). The code does not prescribe a particular format for giving information to the police. The information may be given to the police either by word of mouth or in writing. If it is oral, it shall be the duty of the SHO to reduce the information into writing in the language known to the informant. There should not be any inordinate delay in lodging the information. If there is any delay the reasons for the delay should be explained. The informant is entitled to get a copy of the FIR at free of cost. If the SMO refuses to register the information, the aggrieved may send the same information to the Superintendent of Police concerned, who on his satisfaction that such information discloses the commission of an offence, shall investigate the case himself or direct information to be made by any police of five subordinate to him²⁴⁶.

²⁴² Section 28(2) Cr.P.C.

²⁴³ Section 28(3) Cr.P.C.

²⁴⁴ Section 829 (2) Cr.P.C.

²⁴⁵ Section 29(3) Cr.P.C.

²⁴⁶ Section 151-152 of Cr.P.C.

The person aggrieved may also lodge a private complaint under section 200 of the Cr. P.C before a Magistrate. However, a private complaint cannot be entertained unless the complainant has produced prima facie evidence before the court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor. After taking/recording the statement of witnesses and hearing the prosecution and the accused, the court passes the order of conviction or acquittal of the case. A complaint may be lodged with the Executive Magistrate under sections 133 to 135 of the code against 'quacks' or persons practicing unauthorizedly in any area on the ground of threat to the lives of the public.

5.6.4. Issues

One of the crucial questions which needs to be addressed is, what is the standard of negligence required to be proved in fixing criminal liability on a or a surgeon? As it involves complication, it deserves a brief discourse on concepts of rashness and negligence before proceed to the standard or degree of negligence.

5.6.5. Rashness and negligence:

It is argued that rashness and negligence are not the same thing which can be used interchangeably. Negligence cannot be construed to mean rashness. There are different degrees of negligence and rashness²⁴⁷. Rashness means 'recklessness'. A reckless act has to be understood in two different senses 'subjective' and 'objective.' In the subjective sense, it means deliberate or conscious act, taking risk of danger knowing that some ill effects will follow. In this context, it is almost equivalent to doing act intentionally. In the objective sense, the actor is not conscious of the result although he ought to be aware that it might follow and in this sense it amounts of negligence. Culpable negligence is acting without the consciousness, that the illegal and mischievous effect will follow but in the circumstances which show that he has not exercised the caution, care or attention incumbent upon him, if he had he would have exercised the consciousness. As between rashness and negligence, rashness is a graver offence²⁴⁸. In order to constitute criminal rashness or criminal negligence, one must find out that rashness is of such a degree where the actor knows injury is most

²⁴⁷ Krishnaprasad vs. State of Karnataka, 1989 ACJ 593 at para 13.

²⁴⁸ Cr. L.J. 2005, Journal p. 385.

likely to be caused. Thus, criminality lies in running the risk or doing the act knowing that it involves obvious and serious risk, but indifference to the consequences. Criminal negligence is the ‘gross’ and ‘culpable neglect’ or failure to exercise that reasonable and proper care and precautions to guard against injury²⁴⁹.

5.6.6. Standard of Negligence: Gross Negligence

5.6.6.1. English Law

Generally speaking, it is the amount of damages incurred which is determinative of the extent of liability in tort law/civil law; but in criminal law it is not the amount of damages but the amount and degree of negligence that is determinative fact of liability. To fasten liability on a doctor in criminal law, the degree of negligence to be proved should be so high as can be described as ‘gross negligence or recklessness.’ It is not merely, lack of necessary care, attention and skill. There is a clear distinction between ‘simple lack of care’ incurring civil liability and ‘very high degree of negligence’ which is required in criminal cases. A high degree of negligence is required in order to establish a criminal offence than what is sufficient to create civil liability²⁵⁰.

In *R Vs Bateman*²⁵¹ Lord Hewat observed –

“in explaining to juries the test which they should apply to determine whether the negligence, in the particular case, amounted or did not amount to a crime, judges have used many epithets such as ‘;culpable,’ ‘criminal,’ ‘gross,’ ‘wicked,’ ‘clear,’ ‘complete.’ But whatever epithet be used and whether an epithet be used or not, in order to establish criminal liability, the facts must be such that in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of other as to amount to a crime against the state and conduct deserving punishment.”

In *Andrews Vs DPP*²⁵² Lord Atkin observed that “*a simple lack of care such as will constitute civil liability is not enough. For the purposes of criminal law there are degrees of negligence and a very high degree of negligence is required to be proved before the felony is established.*” In *R Vs Robinson*²⁵³ wherein the death of a patient occurred due to the negligence of the doctor, it was admitted that prosecution

²⁴⁹ Ibid note 246.

²⁵⁰ Lord Atkin per se, *Andrews vs. Director of Public Prosecution* (1937) AC 576.

²⁵¹ (1925) 19 Cr. Appeal Rep 8,89 JP 162, 94 LJKB 791.

²⁵² Supra note 249.

²⁵³ (1977) 2 All ER 341.

must prove *gross negligence*. It was proof of a high degree of negligence reflecting the **Andrews case approach** which was necessary and not the proof foresight of consequences. Taking the passage from Andrew's case, Geoffrey, LJ said, one must try to discover the definition of the requisite degree of negligence. "*Mere inadvertence is not enough; the defendant must be proved to have been indifferent to an obvious risk of injury to health, or actually to have foreseen the risk but nevertheless have proceeded to it.*"

The following is the test to decide the charge of criminal negligence in medical accidents:

- a) Indifference to the obvious risk of injury to health;
- b) Foresight of risk coupled with determination to do it;
- c) An appreciation of the risk coupled with an intention to avoid it, but attempted avoidance involves a high degree of negligence which justifies conviction; and
- d) Inattention in respect of obvious and serious risk which the defendant's duty demands, he should address²⁵⁴. In brief, it can be said that according to English law, the proper test in case of breach of duty by professionals such as doctors is "the gross negligence test."

5.6.6.2. Indian Scenario

5.6.6.2.1. Pre-independent era

Now, coming to the Indian conditions, where section 304-A, IPC requires only a rash or a negligent act in order to sustain a conviction, it is necessary to examine how far is the application of gross-negligence test justifiable?

The "gross negligence" test was applied in the case of *Idu Beg Vs. Reg*²⁵⁵ where the court observed that while negligence is an omission to do something which a reasonable man, guided upon those considerations, which ordinarily regulate the conduct of human affairs, would do or doing something which a prudent and reasonable man would not do; criminal negligence is the gross and culpable neglect or failure to exercise that reasonable and proper care and precautions to guard against injury either to the public generally or to an individual in particular which having

²⁵⁴ R vs. Adomoko (1993) 4 All ER 935 (CA) affirmed by (1994) 3 all ER 79 (HL)

²⁵⁵ (1881) 3 ILR 116, (All).

regard to all the circumstances out of which the charge has arisen, it was the imperative duty of the accused person to have adopted²⁵⁶.

In H.W. Smith Vs State²⁵⁷ the court observed- what should be the standard of care in determining the guilt of causing death by negligence including medical negligence depends directly on the questions as to what is the amount of care and circumspection which a prudent and reasonable man would consider to be sufficient upon all the circumstances of the case. The courts should keep out of one's mind the prejudice that invariably creeps in by reason of the fact that lives have been lost and responsibility of the same ultimately rests with more else but the accused. In John Oni Akerele Vs. The King²⁵⁸ where a duly qualified medical practitioner prepared an injection by dissolving some sobita powder in water which he gave to 57 children of whom 5 died and others fell ill. However, what was administered was overdose of sobita. The doctor was accused of manslaughter, reckless and negligent act. Ultimately the matter reached in appeal before the House of Lords, where their Lordships quashed the conviction by holding that,

- i) That a doctor is not criminally responsible for a patient's death unless his negligence or incompetence went beyond a mere matter of compensation between subjects and showed such disregard for life and safety of others so as to amount to a crime against the state.
- ii) That the degree of negligence required is that it should be gross and that neither a 'jury nor a court can transform negligence of a lesser degree into gross negligence merely by giving at that appellation... there is a difference in kind between the negligence which gives a right to compensation and negligence which is a crime²⁵⁹.

Their Lordships refused to accept the view that criminal negligence was proved merely because a number of persons were made gravely ill after receiving and injection from the appellant coupled with finding that a high degree of care was not

²⁵⁶ Law laid down by Straight, J. in Idu Beg vs. Empress, has been held good in the case of Balachandra Waman Pathe vs. State of Maharashtra, 1968 ACJ 38 (SC).

²⁵⁷ AIR 1926 Cal. 300.

²⁵⁸ AIR 1943 PC 72.

²⁵⁹ Gulam Saeed vs. State (AIR 1953 Madh Bha 180) where the court observed that "in order to establish criminal liability, the facts must be that the negligence of the accused sent the case beyond a mere matter of compensation and showed such disregard for the life and safety of others so as to amount to a crime."

exercised. In *Emperor vs. Omkar Ram Pratap*²⁶⁰ Sir Lawrence Jenkins while dealing with section 304-A of IPC, emphasized the requirements for holding criminal liability; that the death caused by rash or negligent act of the accused and proximate cause to the death without intervention of another's negligence.

5.6.6.2.2. Post independent era till 1990s:

5.6.6.2.2.1. Doctor prescribing poisonous medicine:

In *Juggankhan Vs. State of Madhya Pradesh*²⁶¹ where a registered homeopathy practitioner administered 24 drops of stramonium and a leaf of dhatura (which are known poisonous substances) on a patient to cure guinea worms. The patient for this reason died. It was brought on record of the court that in no system of medicine except perhaps in the ayurvedic system, the dhatura leaf is given as cure for guinea worms. The Supreme Court held that it was rash and negligent act to prescribe poisonous medicines without studying their probable effects. It was true that care should be taken before imputing criminal negligence to a professional man acting in the course of his profession, but even taking this care, there is no doubt that that the appellant was guilty of rash and negligent and liable to be convicted under section 304-A of IPC.

5.6.6.2.2.2. Administering wrong injection without qualifications

In *Ram Nivas vs. State of Uttar Pradesh*²⁶² a person without possessing required qualification to be a doctor administers a full dose of an injection which resulted in death of his patient. The evidence shows that the accused did not give any test dose to the deceased before administering the full dose of the injection. The accused simply denied the very giving of injection which was proved by the prosecution instead of pleading that the injection was such that in all probability it could not have caused the allergic reaction and so the giving of a test dose was not necessary for the death of the patient. The court held that the accused not being a qualified doctor, an injection given without the test dose and the immediate and subsequent death of the person so injected shows not only that the death was the direct consequence of administering the injection, but also that he acted with rashness,

²⁶⁰ (1902) (4) Bom LR 679.

²⁶¹ AIR 1965 SC 831; 1965(1) Cr LJ 763.

²⁶² 1968 Cr.LJ 635 (All)

recklessness, negligence and indifference to the consequences. It amounted to taking a hazard of such degree, that the injury was most likely to be occasioned thereby. So it amply established that the accused, caused the death of the deceased by doing the said rash and negligent act, which did not amount to culpable homicide. The accused was convicted by the trial court under section 304-A of IPC to undergo sentence of one year's of imprisonment²⁶³.

5.6.6.2.2.3. Hakim not educated in allopathic treatment administers penicillin treatment

In the case of *Dr. Kusaldas Pammandas Vs. State of Madhya Pradesh*²⁶⁴ where it was held that if a person is totally ignorant of the science or medicine or principles of surgery and perform an operation or undertakes a treatment, inference of gross negligence and rashness can be easily drawn. In this case, the accused a hakim registered under the Madhya Bharat Indian Medicine Act 1952 administered a procaine penicillin injection to the patient without the knowledge or study of penicillin treatment, resulting in the death of the patient. The question was whether he had any knowledge of penicillin treatment, the precautions to be taken before giving such an injection and the remedies that should be applied for combating any adverse reaction to the injection. The petitioner's ignorance of knowledge of allopathic medicine was taken to be clearly rash and negligent act within the meaning of section 304-A IP. The court while confirming the conviction of the petitioner, observed that no doubt hakims and vaidhya are legitimately entitled to exercise their profession for which they have been trained. But at the same time it is necessary that they should not dabble (play) in medicines and treatment of which they have no knowledge. It is very essential that the public and especially the poorer section of the public, who very often rely upon such practitioners as Hakkim and Vaidyas, should be protected from ignorant experiments of dangerous character.

5.6.6.2.2.4. Criminal negligence not established:

It should be noted that any person who without possessing required qualification and not having knowledge of particular branch of medicine practices

²⁶³ However, the High Court enlarged him on bail under the First Offenders Probation Act 1938 with a condition of furnishing two securities.

²⁶⁴ AIR 1960 Madh Pra 50: 1960 Cr. L. J. 324.

medicine and thereby causes death of any patient; he could be convicted under section 304-A of IPC. However, the court is very cautious in holding a qualified practitioner criminally responsible for patient's death due to error of judgment or mistake in administration of treatment. It is very seldom to come across case where a doctor is convicted for criminal negligence.

5.6.6.2.2.4.1. Administration of coramine injection to an asthma patient

In Ghanshymdas Bhagwandas Vs. State of Madhya Pradesh²⁶⁵ the accused doctor is holding a degree from the Board of Indian Medicines, Madhya Pradesh and practicing medicine. After examining a patient who came to his dispensary, the accused-doctor gave one coramine injection as there was heavy coughing and there was difficulty in breathing. Thereafter the patient collapsed. According to the expert opinion coramine injection should not be given to a asthma patient. But the post mortem report does not show that the coramine injection was the proximate cause of the death. On the other hand, it mentions that the death was due to obstruction of bronchie (windpipe) in both the lungs which led to suffocation and respiratory failure. There is no material on record to sustain charge that it was due to thin injection that the death was caused to the deceased. The court quashed the charge framed against the accused U/s 304A of IPC and discharged him from the case on the ground that there was *no direct nexus* between the death of a person and the rash or negligent act of the accused. Accordingly, there was no negligence on the part of the physician²⁶⁶.

5.6.6.2.2.4.2. Direct nexus between the death and the negligent act

In the case of State of Maharashtra vs. Yashwant Mahadev²⁶⁷ the medical officer performed tubectomy operation and the patient died some days after the operation but the post-mortem showed death by perforation of intestine, the Medical Officer was given the benefit of doubt. In Syed Akbar Vs. State of Karnataka²⁶⁸ it was held that in the criminal proceedings where the negligence is an essential ingredient of the offence, the negligence to be established by the prosecution must be culpable or

²⁶⁵ 1977 ACJ 182.

²⁶⁶ Suleman Rahman vs. St. of Maharashtra (1968 ACJ 51) has held that the requirements of section 304A are that the death of any person must have been caused by the accused doing any rash or negligent act. In other words, there must be proof that the rash or negligent act of accused was the proximate cause of the death. There must be direct nexus between the death of a person and the rash or negligent act of the accused.

²⁶⁷ 1979 ILR (Mah) 504.

²⁶⁸ 1980 ACJ 38 (SC).

gross, and not negligence merely based upon the error of judgment. In *Ajit Kaur vs. St. of Punjab* where the Medical Officer administered drop and other medicines to force labor pains and the child was born but died seven days after the birth. The court held that the administration of medicines by the Medical Officer was not the proximate cause of the death of the child, in assessing penal responsibility, a very high degree of negligence must be established, negligence must amount to recklessness or utter indifference to consequence and not merely negligence of tort, the M.O. was acquitted of charge²⁶⁹.

5.6.6.2.4.3. Caesarean operation performed under local anesthesia without giving test dose

In *Dr. Krishna Prasad vs. State of Karnataka*²⁷⁰ the deceased who was the wife of the complainant admitted to the nursing home as it was her first delivery. It was found that the deceased feet were swollen, the child had developed and it was not possible to push down the head of the child through the pelvis as the pelvis passage was very narrow. Even after administering the required injection, the accused-doctor found that the deceased was getting pain and the head of the child was not still going to the pelvis passage. The doctor came to the conclusion that in order to save the child and the mother, there was no other alternative but to carry out caesarean operation. The parents of the deceased gave the consent to the operation, the doctors decided to perform operation under local anesthesia as they thought that the general anesthesia would affect the child. Soon after local anesthesia was administered blood pressure began to fall, with all the efforts to save the child and the mother, the blood pressure did not come up. The accused examined the deceased and found her heart had stopped beating, immediately he injection to the heart and did internal cardiac massage but it was of no use. The complainant lodged the case U/s 304A against the doctor who administered anesthesia contending that he was not an anesthetic expert and he did not give a test dose. The question was whether the death caused due to rash and negligent act of the doctor. The court held that anesthesia used was a common local anesthesia that is normally given to all the patients and non-giving of a test dose was not an indication of rashness or negligence, the treatment given was proper, fair, competent and reasonable. However, it was unfortunate that the dead body of the

²⁶⁹ 1986 ACJ 696.

²⁷⁰ 1989 ACJ 393.

patient was not subject to post-mortem examination and the organs of the body were not subjected to histo-pathological examination. There was no evidence to show that whether the deceased died due to the administration of anesthesia or due to some other reasons. The due to the lack of evidence, the court quashed the proceedings.

5.6.6.2.4.4. Death of a patient on the operation table due to cardiac arrest

In *Dr. Ved Khuller vs. State*²⁷¹ the petitioner who is a doctor by profession practices medicine in his clinic. She has been charged by police for the commission of an offence under section 304-A of Penal Code. The case of the prosecution is that the death of a patient on the operation table due to cardiac arrest was caused by the accused-doctor's negligence. The doctor was arrested and produced before the court of Chief Judicial Magistrate. The doctor argues that there is not an iota of evidence on the file showing that the deceased died due to cardiac arrest as a result of any negligence on his part and he has been wrongly charged with the offence punishable U/s 304-A. On the perusal of evidence, it was held that nothing has been shown that the doctor did not take sufficient care while performing preliminaries to the operation; in order to perform an operation, surgical interference was necessary and if it has caused cardiac arrest, it cannot be attributed in any manner to the negligence of the doctor. Mere carelessness is not sufficient for a conviction U/S 304-A. This section requires a 'mens rea' or 'guilty mind' and the rashness or negligence must be such as can fairly be described criminal. The court quashed the criminal proceedings pending against the doctor-petitioner.

5.6.6.2.4.5. Death of a patient due to reaction caused by the injection

In the case of *State of Gujarat Vs Dr. Maltiben Valjibhai Shah*²⁷² the respondent treated the patient who complained of sinusitis (inflammation of a lining a sinus =bone containing air) and hypertension. The patient died due to reaction caused by injection. The trial held the doctor guilty of an offence punishable under section 304-A and awarded simple imprisonment for 7 days and fine. However, on the issue of whether the doctor was rash or negligent so as to attract the application of section 304-A of IPC, the high court held that when test dose is given before administering an injection and the deceased did not react to it, it cannot be said that the act of the

²⁷¹ 1988 ACJ 328.

²⁷² 1994 ACJ 375.

doctor was rash and after giving a regular dose when reaction was noted and immediate treatment for anti-reaction has been seriously taken suggests that the doctor was not negligent; giving a regular dose after a test dose cannot be said to be reckless or an impetuous act and doctor was acquitted. The court observed that unfortunately, the patient succumbed to reaction and expired but it was the responsibility of the prosecution to prove the facts to constitute an offence and mere absence of the evidence from the doctor does not lead to inference that the doctor was rash and negligent²⁷³.

5.6.6.2.2.4.6. Causing death of patient while performing operation attracts civil law and not criminal law

In *Dr. Lakshmanan Prakash Vs The State and another*²⁷⁴ the petitioner urged the High Court to quash the proceedings of the Metropolitan Magistrate, for the offence under section 304-A of IPC with the present application filed under S. 482 of Cr.P.C. The state filed the charge sheet alleging the petitioner and others had acted in a rash and negligent manner in conducting the operation on the patient for his fractured injuries sustained on his right leg in a road accident. As a result, the patient died due to failure on part of Anaesthetist to check up during the pre-operative anaesthesia test as to whether the patient would withstand local anaesthesia drug which was administered through spinal cord to the patient. The court held that there was failure on the part of the petitioner to check up performance of medical formalities through Anaesthetist before commencing operation might reflect negligence under civil law and not under criminal law. The court set aside the proceeding initiated under section 304-A against the petitioners and directed the complainant to approach proper forum to claim damages by invoking civil law.

²⁷³ In *Dr. Devendranath Tripathy and others vs State of Orissa and others* (1991 ACJ 619), the charge sheet was filed against the respondents under section 304-A read with section 34 of IPC alleging that death of a patient in operation theatre due to asphyxia caused by heavy dose of anaesthesia. The court held that there was no intention of causing death or knowledge that by such act the patient was to meet his death, therefore, cognizance of the offence taken under section 304-A read with section 43 was liable to be set aside.

²⁷⁴ 1999 CRILJ. 2348.

5.6.6.2.3. Doctors and Criminal Law: 2000 onwards

5.6.6.2.3.1. Gross negligence

In *Suresh Gupta Vs Government of NCT of Delhi*²⁷⁵, the accused (plastic surgeon) charged for offences under section 80, 86 and 304-A of IPC for causing death of his patient who was operated by him for removing his nasal deformity. Medical experts opined that there was negligence on the part of accused in “not putting a cuffed endotracheal tube of proper size” as to prevent aspiration of blood from the wound in the respiratory passage. The question to be decided was whether the act attributed to the doctor can be described to be so reckless or grossly negligent as to make him criminally liable? Quashing the criminal proceedings pending against the doctor, the Supreme Court laid down clearly that high degree of negligence is necessary to prove the charge of criminal negligence under section 304-A of IPC. For fixing criminal liability on a doctor or surgeon, the standard of negligence required to be proved should be so high as can be described as “gross negligence” or recklessness”. It is not merely lack of necessary care, attention and skill. When a patient agrees to go for medical treatment or surgical operation, every careless act of the medical man cannot be termed as ‘criminal’. It can be termed ‘criminal’ only when the medical man exhibits a gross lack of competence or inaction and wanton indifference to his patient’s safety and which found to have arisen from gross ignorance or gross negligence. Where a patient’s death results merely from error of judgment or an accident, no criminal liability should be attached to it. Mere inadvertence or some degree of want of adequate care and caution might create civil liability but would not suffice to hold him criminally liable²⁷⁶.

For every mishap or death during medical treatment, the medical man cannot be held criminally liable, but to convict a doctor, the prosecution has to come out with a case of high degree of negligence on the part of the doctor. Mere lack of proper care, precaution and attention or inadvertence might create civil liability but not a criminal one. Finally, giving a decision in favour of doctor, protecting him from criminal liability the court held that there was no case of recklessness or gross negligence has been made out against the doctor to compel him to face the trial for

²⁷⁵ AIR 2004 SC 4091 (DB).

²⁷⁶ Ibid Para 21.

offence under Section 304-A of the IPC²⁷⁷. The approach of the Supreme Court makes it clear that there should be strong medical evidence pointing the guilt of the doctor without which it would be doing injustice to the health community at large. The court believed that if criminal liability is imposed for the death of a patient due to wrong treatment, then, the doctors would be more worried about their own safety than giving the treatment to their patients and this would ultimately lead to shaking the mutual confidence between the doctor and patient. However, the court has no answer to the question: why the court should think of only the safety of doctors? By protecting the doctors alone, is it possible to foster the mutual relationship of the doctor and patient? The Supreme Court approach appears to be in favour of the accused surgeon.

5.6.6.2.3.2. Guidelines for prosecuting medical professionals

In *Jacob Mathew Vs State of Punjab*²⁷⁸, a case against the petitioners under section 304-A read with section 34 was registered based on the information that a patient who is the complainant's father was admitted in a private ward of C.M.C. Hospital, Ludhiana. On the fateful day, the patient felt difficulty in breathing for which the doctor connected the oxygen cylinder to the mouth of patient but the breathing problem increased further due to the oxygen cylinder was found to be empty. There was no other gas cylinder available in the room and no arrangement had been made to make the gas cylinder functional. In bringing another cylinder from another room, 5 to 7 minutes were wasted. By this time, another doctor declared the patient was dead. The Judicial Magistrate framed charges under section 304-A IPC. Against the two petitioners who are doctors by profession. Both of them filed a revision in the Court of Sessions Judge submitting that there was no ground for framing charges against them. The revision was dismissed; therefore, appellant filed a petition in the High Court under section 482 of the Code of Criminal Procedure praying for quashing of the F.I.R. and the subsequent proceedings. However, the High Court dismissed the petition, stating they could defend at the trial. Feeling aggrieved by this order, the appellant filed appeal by special leave. As the question of

²⁷⁷ The court relied on the decision of the House of Lords in *R. v. Adomako* (1994) 3 All ER 79 Para 6 20, wherein it was observed “ thus a doctor cannot be held criminally responsible for patient's death unless his negligence or incompetence showed such disregard for life and safety of his patient as to amount to a crime against the State.”

²⁷⁸ 2005 ACJ 1840, Bench comprising Mr. R.C. Lahoti CJI, Mr. G.P. Mathur J and Mr. P.K. Balasubramanyan J.

medical negligence arose for consideration, a registered society- 'People for Better Treatment', Kolkata; Delhi Medical Council, Delhi Medical Association and Indian Medical Association joined the case as interested parties²⁷⁹.

The Supreme Court observed that for the negligence to constitute an offence, the element of mens rea must be present. For an act to amount to criminal negligence, the degree of negligence should be much higher, i.e. gross or a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action civil law but cannot form the basis for prosecution. The word 'gross' has not been used in section 304-A of I.P.C., yet it is settled that in criminal law negligence or recklessness must be understood to be 'gross'. The expression 'rash or negligent act' as occurring in section 304-A of the I.P.C. has to be read as qualified by the word 'grossly'²⁸⁰.

For the prosecution of doctors for the offences of which criminal rashness or criminal negligence is an ingredient, (a) a private complaint cannot be entertained unless the complainant has produced prima facie evidence before the court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the party of the accused doctor. (b) the investigating officer should proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion from a doctor in government service who can normally be expected to give an impartial and unbiased opinion applying **Bolam's** case test to the facts collected in the investigation. (c) a doctor should not be arrested in routine manner simply because a charge has been leveled against him unless his arrest is necessary for furthering the investigation or for collecting evidence or investigation officer feels satisfied that the doctor proceeded against would not make himself available to face prosecution unless arrested.

The above propositions of the Apex Court will have two implications on the language of Section 304-A of the I.P.C. Firstly, it introduces the word 'gross' into section 304-A and secondly, it accords some privileges on the medical professionals

²⁷⁹ Ibid Para 9.

²⁸⁰ In view of the principles laid down above, the court agreed and re-affirmed the principles of law laid down in Dr. Suresh Gupata's case.

in relation to the investigation of criminal medical malpractice. The word ‘gross’ which is suggested by the court as a part of the language of Section 304-A appears to be ambiguous as it is not susceptible of precise definition and also contrary to the letter and spirit of Section 304-A. Section 304-A which deals with death caused by rash or negligent act, contemplates those cases in which it requires neither intention nor knowledge. The absence of ‘intention’ is the special feature of the language of Section 304-A. If the intention of the doer were considered, then, every case of gross negligence should become the offence of culpable homicide or manslaughter²⁸¹. Negligence and intention are mutually inconsistent in respect of mental attitude of a person towards his acts and their consequences. No consequence which is resulted from carelessness can be said to have been intended and whatever intended cannot be said to have been caused carelessly²⁸². Therefore, in the criminal law liability for medical negligence is extremely exceptional since crimes are intentional wrongs and a requirement of the mental element (*mens rea*) is a condition precedent for imposing liability. Nonetheless, for an offence punishable under section 304-A of IPC neither intention nor knowledge is required to be proved before liability can be imposed.

5.7. NATIONAL HUMAN RIGHTS COMMISSION

Beside different mechanisms of protecting patients from medical malpractice by the health care provider, there are other mechanisms whose institutions will enhance the existing mechanisms. The present part focuses on the National Human Rights Commission as an alternative means of protecting patients’ rights. NHRC/SHRC can hold the state accountable for violation of human rights of patients. NHRC can play vital role in fulfillment of national and international human rights norms. It accepts complaints regarding violation of human rights and asks for explanations from the government. It is not satisfied with the reply, it starts as independent investigation, in the course of which, the commission among other things can summon and witnesses to appear before it and then examine the under oath. It can also call for relevant documents. In its proceedings; the NHRC is endowed with all the powers of a civil court. Sometimes the NHRC initiates a general public inquiry also. Following investigation, the NHRC can award compensation or can issue

²⁸¹ Benjamin MS and C.B. Raju, “Criminal Clinical Negligence: who watches the life saviour- A critical appraisal, Kar.L.J. 2007(1) p. 26.

²⁸² Chulani, HL, “Professional Negligence under the Indian Penal Code” Cr. L.J. 1996, p. 133.

directions. It has been successful sometimes, in persuading the state to pay compensation to victims of human rights violation. It can also recommend the granting of ‘immediate interim relief’ to a victim of human rights abuse or to his or her relative²⁸³.

5.7.1. Commission directs UP government to pay interim compensation for death of a pregnant woman:

The NGO sent a letter to the Commission along with newspaper report which stated that Smt. Bihalavati, wife of Ram Prakash was taken to the District Hospital, Siddhartha Nagar for delivery and through she was experiencing acute labour pain, she was not admitted by the staff nurse as her husband had failed to pay Rs.250/- as demanded by the latter. She was admitted only after other persons paid the amount. At around 1 p.m. when her condition became very serious, a General Duty Medical Officer examined her and referred her to another hospital but before she could be taken to that hospital, she expired. It had been alleged that Smt. Bihalavati died due to negligence and carelessness on the part of doctors of the District Hospital, Siddharth Nagar as her husband had failed to meet their illegal demand. The commission directed the Uttar Pradesh government to pay a sum of aRs.50,000/- by way of interim relief to the next of kin of the deceased due to negligence and carelessness on the part of doctors of the District Hospital²⁸⁴.

5.7.2. Commission intervenes in getting the dead body released²⁸⁵:

Smt. Ram kumari lodged a complaint to the commission stating that her late husband died in a road accident when his truck collided with a tree and caught fire thereafter. The police who prepared an inquest report sent the burnt body of her husband for post-mortem to Rai Bareilly. A team of three doctors performed the autopsy but were unable to give an opinion on the cause and time of death and therefore sought the opinion of the state medico-legal expert. The opinion was delayed by six months, as a result of which the complainant was made to rush from Allahabad to Rai Bareilly to plead with the authorities to hand over the remains of her husband’s dead body for performing the last rites. The complainant sought the

²⁸³ Mihir Desai and Kamayani Bali Mahabal, *Health Care Case Law in India*, CEHAT, 2007, p. 139.

²⁸⁴ <http://nhrc.nic.in/dispArchive.asp?fno=1035>

²⁸⁵ Case No. 7122/24/98-99.

commission's assistance in getting the dead body released early. The commission noted that the bodily remains of the deceased were handed over the complainant nine months after the death; this had resulted in mental agony to her and forced her to rush to Rai Bareilly to contact the authorities. The held that this avoidable delay was directly attributable to gross negligence of the state authorities at different levels. In the circumstances, the commission recommended the payment of interim compensation of Rs.10,000 to the complainant by the government of Uttar Pradesh within two months that has since been paid.

5.7.3. Adverse reaction to the vaccine²⁸⁶:

In a complaint by chairman Social Welfare Council, Nayagarh, Orissa informed the Commission that one Mr. Sethi was bitten by a stray dog and he went to the District Hospital Nayagarh for free shots of the vaccine. But in the hospital rabies vaccine was not preserved in cold storage. He received anti rabies injections on his stomach for seven days, but because of an adverse reaction to the vaccine, he developed partial paralysis and malfunctioning of a kidney. He had no means to undergo treatment in a private hospital and was fighting for his life. The complainant prayed for an independent inquiry into the negligence of the medical personnel of the hospital and adequate compensation for maintenance and treatment of the patient. The commission conducted inquiry and directed department of family and health to pay compensation of Rs.2 lakh for further treatment²⁸⁷.

CONCLUSION

The foregoing discussion reflects that how a patient who intends to sue the doctor or hospital for medical negligence may resort to different mechanisms available under the Constitution and various statutes. In our country, there is no specific law which exclusively deals with the rights and obligations of the health care providers and patients. A patient cannot claim medical service as a matter of right except in emergency cases. Emergency medical service has been interpreted as a right within the scope of Article 21 of the Constitution of India. Where the public health institution refuses to treat a patient in emergency case, the patient may resort to constitutional remedy for deprivation of his right to life. The Supreme Court has held

²⁸⁶ Case No. 359/18/99-2000.

²⁸⁷ Supra note 280 at page 144.

that the failure to provide timely medical service constitutes violation of the fundamental right to life. However, the fundamental right to approach the Supreme Court or the High Court as the case may be, for the enforcement of Article 21 is generally available against public health facilities and not against the private health care sector. Article 32 or 226 of the constitution does not provide a remedy against private hospitals. If a private hospital commits breach of obligations due to the patient i.e. negligence in treatment, the aggrieved will have to approach the civil court for remedy. But the proceeding in the civil court involves litigation expenses, strict proof, and delay in disposal of case. In order to get cheap and speedy remedy, the patient concerned may approach the consumer court under the Consumer Protection Act 1986. However, the burden lies on the complainant to prove that the service availed by him for consideration. The Supreme Court has excluded some medical service from the purview of the Consumer Protection Act such as, services rendered at the government hospitals / health centres / dispensaries on payment of nominal charges and free service rendered to all rich and poor. Thus, a patient availing free services at government hospitals / health centres / dispensaries has not been treated as a consumer, and is not entitled avail to the remedies under the Act. Since the factum of consideration is sine qua non, a patient who is affordable to pay for service is left out without any remedy.

Further, the study of various provisions of the Medical Council Act 1956 reveals that the Act provides for the establishment of the medical council to regulate the conduct of medical practitioners and hospitals but there is vacuum with respect to safeguard the interests of patients who are affected by negligence or deficiency in the service rendered by members of the health service. The Medical Council Act aims at bring in discipline among the members of the medical profession while ignoring the interests of patients. A patient or his next kin may move the criminal court in relation to issues concerning criminal negligence, but securing a medical expert opinion in support of the complaint is more difficult mission. The Supreme Court has observed that a complaint against the doctor cannot be registered unless it is accompanied by the opinion of another competent doctor preferably working in the government hospital in the concerned field. This sort of approach poses a great difficulty for the complaint in prosecuting doctors under the criminal law. Besides, the Human Rights Commission is also available as an alternative way of protecting human rights of

patients, but the commission has failed to monitor the performance of public health institutions due to delay in obtaining information from the state authorities, apathy of the government in taking action against delinquent doctors based on the recommendation and in according sanction for prosecution etc. Thus, it is evident that the existing mechanism for taking action against the delinquent doctor or hospital for medical error, misconduct or negligence is insufficient and therefore, there should be effective mechanism for identifying the scope and extent of accountability of the doctor for medical malpractice.