THE STANDARD OF CARE AND PROOF OF NEGLIGENCE IN MEDICAL PROFESSION – A SHIFT FROM *BOLAM* TO *BOLITHO*

*Kiran Gupta**

I. Introduction

Medicine heals, but this fact does not hold true for every patient. According to World Health Organization one in 10 hospital admissions leads to an adverse event and one in 300 admissions in death. Unintended medical errors have become a big threat to patient safety and WHO lists it among the top 10 killers in the world.

Right to life enshrined in article 21 of the Constitution of india includes right to health. Every medical professional whether at a government hospital or otherwise has the professional obligation to extent his services with due expertise for protecting life. However, medical professionals, despite prudence and care, commits errors in their day to day medical practice such as incorrect diagnosis, wrong treatment and lack of consent. This inherent fallibility in the medical profession is directly related to legal action. Previously, medical professionals were mainly worried about failing to save the life of a patient or providing satisfactory treatment to a sick person. Now, they are also worried about the legal consequences of their failure.

Ever since medical professionals have been brought within the ambit of the Consumer Protection Act 1986,[1] there has been a drastic increase in the number of cases filed against doctors. A good number of patients and their relatives take serious view of medical negligence. Day-by day, more and more medical negligence cases are registered against doctors and surgeons in Consumer Forum. However, it is a great mistake to think that doctors and hospitals are easy targets for dissatisfied patients. They are not liable for everything that goes wrong with the patients. They are only required to exercise reasonable care and skill in their treatment of patients. They will be held guilty of negligence only if they fall short of the standard of a reasonably skillful medical practitioner.

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* Associate Professor, Law Centre-II, Faculty of Law, University of Delhi.

[1] *Indian Medical Association* v. *V.P. Shanta*, AIR 1996 SC 550.

In a case against a doctor, the onus is upon the claimant to prove that the doctor was negligent and that his negligence caused the injury of which the complaint is made. It is he who has to prove that the doctor falls short of the standard of a reasonably skillful medical man. This has to be supported by expert evidence or medical literature on the subject. If the initial burden of negligence is discharged by the claimant, it would be for the doctors to substantiate their defence that there was no negligence. The aim of this paper is to explain how the law of medical negligence operates in India, taking into account the rising doctor-patient conflict and legal intervention.

II. Negligence: Duties And Liabilities Of Medical Professionals

A. Types of liabilities

If a doctor is negligent in the performance of his duties, he is open to both criminal and civil liability. The liability may arise under the Indian Medical Council Act 1956 (professional misconduct), under the Indian Penal Code 1860 (criminal liability) or under the Indian Contract Act 1872 or under the law of tort (civil liability). Medical practitioners are accountable to their own colleagues in the profession in case of violations of the code of medical ethics, to the society for criminal negligence and to the victims for tort and breach of contract.

Negligence is treated as a tort as well as a crime. As a tort it is actionable under the civil law and as a crime under the criminal law. Actions for damages in tort are filed in civil courts and after the coming into force of the Consumer Protection Act 1986, in consumer courts also. Criminal complaints are filed under the Indian Penal Code alleging rashness or negligence. In civil law only damages can be awarded by the court for the loss suffered by the complainant. However, in criminal law the doctor can also be sent to jail, apart from the damages imposed by the civil court or by the consumer forum.

B. Negligence

In common parlance negligence means carelessness, lack of proper care and attention. In law, negligence becomes actionable when it results in injury or damage. Negligence is the breach of a duty caused by the omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affair would

do. or doing something which a prudent and reasonable man would not do.[2] It is the omission to do what the law requires, or the failure to do anything in a manner prescribed by law.

To constitute negligence one has to prove a duty to take care, breach of that duty and the resulting damage. Therefore, the essential components of negligence are:

1. The existence of a duty to take care which the defendant owes to the plaintiff;
2. The breach of that duty towards the plaintiff; and
3. Damage or injury to the complainant as a result of such breach.

C. Medical Negligence

Medical negligence is the failure of a medical practitioner to provide proper care and attention and exercise those skills which a prudent, qualified person would do under similar circumstances. It is a commission or omission of an act by a medical professional which deviates from the accepted standards of practice of the medical community, leading to an injury to the patient. It may be defined as a lack of reasonable care and skill on the part of a medical professional with respect to the patient, be it his history taking, clinical examination, investigation, diagnosis, and treatment that has resulted in injury, death, or an unfavorable outcome. Failure to act in accordance with the medical standards in vogue and failure to exercise due care and diligence are generally deemed to constitute medical negligence.

III. Medical Negligence Under Civil Law

A. Extent of duty of care

The duty of care for a medical professional starts from the time the patient gives an implied consent for his treatment and the medical professional accepts him as a patient for treatment, irrespective of financial considerations. This duty starts from taking the history of the patient and covers all aspects of the treatment, like writing proper case notes, performing proper clinical examination, advising necessary tests and investigations, making a proper diagnosis, and carrying out careful treatment.

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[2] *Blyth* v. *Birmingham Waterworks Company*, (1856) EWHC exch J 65.

In 1969, the Supreme Court in *Laxman Balkrishna Joshi* v. *Trimbak Babu Godbole*[3] held:

> A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for that purpose. He owes a duty of care in deciding whether to undertake the case, he owes a duty of care in deciding what treatment to give and, he owes a duty of care in the administration of that treatment. A breach of any of these duties gives a right of action for negligence to the patient.

This means that when a medical professional, who possesses a certain degree of skill and knowledge, decides to treat a patient, he is duty bound to treat him with a reasonable degree of skill, care and knowledge. If he falls below this, he will be held liable for negligence.

The Supreme Court has deprecated the practice of doctors and certain government hospitals to refuse even primary medical aid to the patients and referring them to other hospitals simply because they are medico legal cases[4]. The Court declared that every doctor whether at a government hospital or otherwise has the professional obligation to extend his service with due expertise for protecting life. The Court also directed that the decision should be given wide publicity so that every doctor wherever he be within the territory of India should forthwith be aware of this position.

B. Standard of Care in Medical Profession

A person who holds himself out ready to give medical advice and treatment, impliedly undertakes that he is possessed of skill and knowledge for the purpose and bring to exercise that skill and competence with reasonable care and diligence. He can be held liable on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. He should possess a certain degree of competence and should exercise reasonable care in discharge of his duties.[5]

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[3] AIR 1969 SC 128.

[4] *Pt. Parmanand Katara.* v. *Union of India*, AIR 1989 SC 2039.

[5] *Supra* n.1.

Medical practitioners operate in spheres where success cannot be achieved in every case and very often success or failure depends upon factors beyond their control. In fact, even the most experienced medical practitioners may fail to detect the true nature of a disease or a condition. The courts consider this while determining the accountability of a medical practitioner when a case against a doctor arises. Consequently a doctor can only be held liable if his mistake was a result of absence of reasonable skill, knowledge and care expected on his part. The standard to be applied for judging ,whether a person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession.[6] The standard is that of a reasonable average.

In *Halsbury's Laws of England* the degree of skill and care required by a medical practitioner is stated as follows:

> The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way; nor is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men.
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> Deviation from normal practices is not necessarily evidence of negligence. To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care.[7]

A doctor has a legal duty to take care of his patient. Whenever a patient visits a doctor for treatment there is a contract by implication that the doctor will take reasonable care to treat him. If there is a breach of

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[6] *Jacob Mathew* v. *State of Punjab,* (2005)6 SCC 1.

[7] HALSBURY'S LAWS OF ENGLAND (4th edn.) vol.30, para 35.

that duty and if it results in injury or damage, the doctor will be held liable. The doctor must exercise a reasonable degree of care and skill in his treatment; but at the same time he does not and cannot guarantee cure. In other words, a doctor is only required to ensure due care in treating the patient. Liability in case of medical negligence arises not when the patient has suffered an injury but when the injury has resulted due to the conduct of the doctor which has fallen below the standard of reasonable care. The skill of medical practitioners may differ from one doctor to another. There may be more than one course of treatment which may be given for treating a particular disease. Medical opinion may differ with regard to the course of action to be taken for treating a patient. As long as the doctor acts in a manner which is acceptable to the medical profession and treats the patient with due care and skill, the doctor will not be guilty of negligence even if the patient does not survive or suffers a permanent ailment.

The law does not condemn the doctor when he only does that which many a wise and reasonable doctor so placed would do. He is not guilty of negligence if he acts in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular task. It only condemns him when he falls short of the accepted standards of that great profession. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his abilities and with due care and caution.[8] The doctor has a discretion in choosing treatment which he proposes to give to the patient and such discretion is relatively ampler in cases of emergency.[9] Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.

There is however, a difference between standard of care on the one hand and degree of care on the other. In the case of a doctor, the standard of care expected of him remains the same in all cases, but the degree of care will be different in different circumstances. Thus, while the same standard of care is expected from a generalist and a specialist, the degree of care would be different. A higher degree of skill is expected from a specialist when compared to that of a generalist.

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[8] *Achutrao Haribhau Khodwa* v. *State of Maharashtra,* AIR 1996 SC 2377.

[9] *A.S.Mittal* v. *State,* AIR 1989 SC 1570.

What amounts to reasonable care changes with the advancement of science and technology. A doctor has to constantly update his knowledge in tune with the changing time with a view to improve the standard expected of him. At the same time, it may not be necessary for the doctor to know all the developments that have taken place in the field as he is supposed to have only reasonable knowledge.[10]

(i) Bolam Test

The basic principle relating to medical negligence is known as the *Bolam rule* . This was laid down by Justice McNair in *Bolam* v. *Friern Hospital Management Committee*[11] as follows:

> Where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. In case of medical men, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. There may be one or more perfectly proper standards and if he confirms with one of these proper standards, then he is not negligent.

As per this case the test for determining medical negligence is the standard of the ordinary skilled man exercising and professing to have that special skill. But the core dispute in medical negligence cases which are defended often centers on just what does constitute proper practice or ordinary competence in relation to the procedure in dispute. The profession itself need not agree whether or not a particular practice amounts to adequate care of the patient's interest. In such cases McNair J. held:

> A doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art...Putting it the other way

[10] *Supra* n.6.

[11] [1957] 2 All ER 118.

> round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.[12]

This statement shows that if a medical practice is supported by a responsible body of peers, then the *Bolam test* is satisfied and the practitioner has met the required standard of care in law. The test has been applied on numerous occasions in cases of medical litigation. A strong endorsement of this test was provided in the House of Lords by Lord Scarman in the case of *Maynard* v. *West Midlands Regional Health Authority*.[13] His Lordship stated:

> A judge's preference for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed and honestly held, were not preferred. ...For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another.

The *Bolam test* allows medical practitioners to set for themselves the legal standard by eliciting the support of 'a responsible body of medical men'. This test has been interpreted to mean that a doctor is not negligent if he has acted in accordance with a practice accepted as proper by a body of medical men who possess similar skills. It is immaterial that there exist another body of opinion that would not have adopted the approach taken by the said doctor. As long as there exist a "responsible body of medical opinion" that approves the actions of the doctor, the doctor escapes liability. In other words, the *test* allows doctors to escape liability by calling experts to testify that procedure adopted was consistent with practices accepted by a responsible body of medical opinion.

Bolam's test has been approved by full bench of the Supreme Court in *Jacob Mathew's* case in these words:

> The water of *Bolam test* has ever since flown and passed under several bridges, having been cited and dealt with in several judicial pronouncements, one after the other and has continued to be well

[12] *Ibid.*

[13] (1984)1 WLR 634 (HL).

> received by every shore it has touched as neat, clean and a well condensed one.[14]

The classical statement of law in *Bolam* case has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been invariably cited with approval before courts in India and applied to as touchstone to test the pleas of medical negligence. In tort, it is enough for the defendant to show that the standard of care and skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be noted. First, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used.

(ii) Bolitho Case

In *Bolitho* v. *City and Hackney Health Authority*,[15] a two year old child, suffered catastrophic brain damage as a result of cardiac arrest due to respiratory failure. The senior pediatric registrar did not attend the child, as she ascribed to a school of thought that medical intervention, under those particular circumstances, would have made no difference to the end result. Liability was denied on the ground that even if she had attended, she would not have done anything that would have materially affected the outcome. This view was supported by an impressive and responsible body of medical opinion. Lord Wilkinson observed;

> The Court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice. The use of these adjectives – responsible, reasonable and respectable – all show that the Court

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[14] *Supra* n. 6, para 20.

[15] (1997) 4 All ER 771 (HL).

> has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving the weighing of risks against benefits, the Judge before accepting a body of opinion as being responsible, reasonable and respectable, will need to be satisfied that in forming their views the experts have directed their minds to the question of comparative risks and benefits, and have reached a defensible conclusion on the matter.

Lord Browne-Wilkinson speaks of cases and emphasizes later in his judgment that it will 'very seldom' be right for a judge to reach a conclusion that views genuinely held by competent experts are unreasonable. On the facts of the claim before him he concluded that there was no basis for dismissing the defendants' expert evidence as illogical. There were sound reasons not to intubate. However, the case laid down that it is not enough for the doctor charged with negligence to prove that he acted in accord with the approved practice to clear him. The practice he followed must has a logical basis so as to be responsible, reasonable and respectable. Thus even though there exists a body of professional opinion sanctioning the defendant's conduct, the defendant can still be held negligent if the judge is not satisfied that the opinion is reasonable or responsible. Ultimately the courts, and only the courts, are the arbiters of what constitute reasonable care. Doctors cannot be judges in their own cause. This is likely to shift the *Bolam's* "accepted practice" approach to one whereby the standard of care is set by the court on the basis of "expected practice."

Recently, Justice S.B.Sinha in *Malay Kumar Ganguly* v. *Dr. Sukumar Mukherjee*[16] case has preferred *Bolitho test* to *Bolam test*. The Supreme Court redefined medical negligence saying that the quality of care to be expected of a medical establishment should be in tune with and directly proportional to its reputation. The Court extended the ambit of medical negligence cases to include overdose of medicines, not informing patients about the side effects of drugs, not taking extra care in case of diseases having high mortality rate and hospitals not providing fundamental amenities to the patient. The decision also says that the court should take into account patient's legitimate expectations from the hospital or the concerned specialist doctor.

[16] (2009) 9 SCC 221.

In this case the patient, a lady aged about 36 years, developed fever along with skin rashes. A doctor was contacted, who after examination of the patient assured of a quick recovery and advised her to take rest but did not prescribe any medicine. As the skin rashes reappeared more aggressively, the doctor was again contacted who diagnosed that she was suffering from Anglo- Neurotic Oedema with allergic vasculitis and prescribed long acting steroid, depomedrol injection 80 mg twice daily for three days and wysolone which is also a steroid having the composition of Methyl predinosolone. As the condition of the patient deteriorated rapidly from bad to worse despite the administration of the said medicines, she was admitted to the hospital wherein it was found by the attending doctors that the patient has been suffering from Toxic Epidermal Necrolysis (TEN). Doctors in the hospital prescribed a quick acting steroid prednisolone at 40 mg three times daily. The condition of the patient continued to deteriorate further. She was shifted to Breach Candy Hospital, Mumbai wherein she breathed her last after 10 days. The cause of the death was found to be septicemia which happened as a result of profound immuno-suppression, caused by over use of steroid and lack of supportive therapy and care on the part of attending doctors.

Complainant, the husband of the deceased, apart from filing criminal case and lodging a complaint in the West Bengal Medical Council, filed a complaint against the doctors and hospital in the National Consumer Dispute Redressal Commission (NCDRC) claiming a total compensation of more that Rs. 77 crores. The NCDRC dismissed the complaint. Aggrieved complainant came in appeal to the Supreme Court.

He pleaded that Doctors from the very beginning should have referred the deceased to a Dermatologist as she had skin rashes all over her body. Doctors had made a wrong diagnosis of the deceased's illness and prescribing a long acting corticosteroid depomedrol injection at dose of 80 mg twice daily was wrong which led to her death. He also asserted that no supportive therapy which is imperative in TEN cases was given in the hospital. Doctor's on the other hand, alleged that there had been no negligence or deficiency in service on their part as they prescribed medicines as per the treatment protocol noted in the text books.

After a protected trial and hearing and on consideration of the evidence and material produced on record, the Supreme Court decided

that doctors and hospital were negligent in treating the patient. The court found that there is cleavage of opinion on the medical protocol for treating TEN patients. The cleavage of opinion is between pro-steroid and anti-steroid group. The court, in view of difference of opinion amongst experts, proceed on the assumption that steroid can be administered to the TEN patients. However, treatment of the patient was not found to be in accordance with the medical protocol of pro-steroid group. The treatment line followed by the doctor in administering 80 mg of Depomedrol injection twice daily is not supported by any school of though. Those who support steroid for TEN treatment do not recommend long acting steroid which Depomedrol is. The proper dose as per the manufacturer of Depomedrol is 40-120 mg once in 1-4 week interval – 80 mg twice daily is highly excessive.

The court is not bound to hold that a doctor escape liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that his treatment or diagnosis accorded with sound medical practice. The court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. The judge before accepting a body of opinion as being responsible, reasonable and respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.

It was observed that the law on medical negligence also has to keep up with the advances in the medical science as to treatment as also diagnostics. Doctors increasingly must engage with patient during treatment especially when the line of treatment is a contested one and hazards are involved. Standard of care in such cases will involve duty to disclose to patients about the risks of serious side effects or about alternative treatment. The standard of duty to care in medical services depends on the position and stature of the doctors concerned as also the hospital. The premium stature of services raises a legitimate expectation. If representation is made by a doctor that he is a specialist and ultimately it turns out that he is not, deficiency in medical services would be presumed.

The court found the doctors to be negligent and deficient in providing medical services as:

(1) Patient had rashes all over her body, the doctor should have referred her to a dermatologist.

(2) Doctor wrongly diagnosed the disease as vasculitis.

(3) The doctor prescribed "Depomedrol" 80 mg twice a day for three days which is certainly a higher dose in case of a TEN patient and the maximum recommended usage by the drug manufacturer has also been exceeded. This is a wrongful act on his part. The immediate adverse effect of overuse of this steroid is immunosupression and chance of infection.

(4) According to general practice, long acting steroids are not advisable in any clinical condition. Instead of prescribing a quick acting steroid, the prescription of a long acting steroid without foreseeing its implications is an act of negligence on their part without exercising any care or caution.

(5) After prescribing a steroid, the effect of immunosuppression caused due to it, ought to have been foreseen. The doctors fail to take notice of said consequences.

(6) The doctors in hospital, after taking over the treatment of the patient did not take any remedial measure against the excessive amount of Depomedrol that was already stuck in the patient's body. On the other hand, they prescribed an excessive dose of quick acting steroid.

(7) Aggressive supportive therapy that is necessary for TEN patients was not provided in the hospital.

(8) The hospital is liable to prevent nosocomial infections specially in the cases where the patient has high risk of infection due to the nature of the disease suffered or immunosupression caused due to use of steroids.

In the opinion of Court for the death of the patient although doctors and the hospital were negligent, it cannot be said that they should be held guilty for criminal negligence. For an act to amount to criminal negligence, the degree of negligence must be of a gross or a very high degree. A negligence which is not of such a high degree may provide ground for action in civil law but cannot form the basis of prosecution.

The court remitted the case back to the NCDRC for the purpose of determination of quantum of compensation. NCDRC finally awarded a compensation of Rs. 1,55,58,750 to be paid by the doctors and the hospital.

In *V.Kishan Rao* v. *Nikhil Super Speciality Hospital*[17] the Supreme Court expressed the opinion that *Bolam test* needs to be reconsidered in India in view of Article 21, which guarantees right to medical treatment and care. However, the Court expressed its inability because of the binding precedent of *Jacob Mathew*[18] which approved the test.

In *Kusum Sharma* v. *Batra Hospital and Medical Research Centre*,[19] the apex court reiterated the legal position after taking survey of catena of case law. In the context of issue pertaining to criminal liability of a medical practitioner, Hon'ble Mr. Justice Dalveer Bhandari speaking for the Bench, laid down that the prosecution of a medical practitioner would be liable to be quashed if the evidence on record does not project substratum enough to infer gross or excessive degree of negligence on his/her part.

In this case appellant's husband was admitted to the respondent hospital. He was diagnosed to be having tumor in the left adrenal which was suspected to be malignant. Surgery was performed by adopting anterior approach and left adrenal was removed. During the surgery, the body of the pancreas was damaged which was treated and a drain was fixed to drain out the fluids. He was discharged from the hospital with an advice to follow up and for change of the dressing. He did not visit the respondent hospital for follow up. Instead, he took treatment from other hospitals. After few months, he died on account of pyogenic meningitis. After his death, appellant filed a complaint before the National Commission claiming compensation attributing medical negligence in the treatment by the doctors at respondent hospital. Her main plea was that the anterior approach adopted at the time of first surgery was not the correct approach, surgery should have been done by adopting 'posterior' approach for removal of left adrenal tumor. National commission found no merit in the claim of the appellant taking into consideration the medical literature and evidence of

[17] (2010) 5 SCC 513.

[18] *Supra* n. 6.

[19] (2010) 3 SCC 480.

eminent doctors of AIIMS confirming adoption of 'anterior' approach in view of inherent advantages of the approach. Against that order the appellant came in appeal to the Supreme Court.

Dismissing the appeal, the court held that in the instant case, the doctors who performed the surgery had reasonable degree of skill and knowledge and they in good faith and within medical bounds adopted the procedure which in their opinion was in the best interest of patient. Doctors could not be held to be negligent where no cogent evidence to prove medical negligence was produced by the appellant. The medical texts speak of both the approaches for adrenalectomy as adopted in the present case. Nowhere has the appellant been able to support her contention that posterior approach was the only possible and proper approach and respondent was negligent in adopting the anterior approach.

(iii) Consent: Disclosure of Information

The legal precedent for consent arises from the case *Schloendorff* v. *Society of New York Hospital*[20] in 1914 in New York state, in which a surgeon failed to take consent for hysterectomy. Benjamin Cardoza, J. observed:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body and the surgeon who performs operation without his (patient's) consent commits assault for which he is liable in damages.

It is a moral obligation of medical professionals to disclose the necessary information to their patients, though the nature and extent of the disclosure and the legal obligation varies from one jurisdiction to another and from one country to another. A legally valid consent requires the patient to be provided with adequate information by the physician about the proposed course of treatment, its probable complications, possible alternatives and their consequences, and so on.

Various criteria have been proposed as both legal and moral standards for adequate disclosure of information, like the reasonable doctor standard(what a reasonable doctor thinks that a patient should know), the reasonable man standard (what a reasonable man under similar

[20] 105 NE 92 (1914).

circumstances would like to know), and the subjective standard (what a particular patient, rather than a hypothetical reasonable person, considers adequate information).[21] *Natanson* v. *Kline,*[22] held that it was the amount of information that a reasonable doctor would provide. *Canterbury* v. *Spence,*[23] held it was that amount of information which a reasonable patient would need to make a medical decision. The court observed that;

> A risk is...material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks, in deciding whether or not to forego the proposed therapy. The doctor, therefore, is required to communicate all inherent and potential hazards of the proposed treatment, the alternative to that treatment, if any, and the likely effect if the patient remained untreated. This stringent standard of disclosure was subjected to only two exceptions:
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> (i) Where there was a genuine emergency, e.g. the patient was unconscious; and
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> (ii) Where the information would be harmful to the patient, e.g. where it might cause psychological damage, or where the patient would become so emotionally distraught as to prevent a rational decision.

The English law regarding disclosure of risk follows the *Bolam* principle. In *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital and the Mandsley Hospital,*[24] the House of Lords adopted the *Bolam test* and followed the reasonable doctor standard regarding the duty of disclosure of risk of proposed treatment. It was considered that full disclosure of risk according to the principles of informed consent is not an appropriate test for liability for negligence. The *Canterbury* doctrine was rejected as it was thought to be impractical and meaningless because it did not give sufficient value to the realities of the doctor-patient relationship. Lord Bridge, however, made it clear that it is the duty of the doctor to answer correctly and fully all the queries of the patient. He further held that remote risk of damage (referred to as risk at 1 or 2 per

[21] T.L. Beanchamp and J.F. Childress, PRINCIPLES OF BIOMEDICAL ETHICS (5th ed., New York, 2001) p. 81.

[22] (1960) 186 Kan. 393, 350 p. 2d 1093.

[23] (1972) 464 F 2d. 772.

[24] (1985) 1 All ER 643.

cent) need not be disclosed. However, if the risk of damage is substantial (referred to as 10 per cent risk), it may have to be disclosed. However, Lord Woolf, in *Pearce* v. *United Bristol Healthcare NHS Trust,*[25] accepted the 'reasonable patient test' and the 'doctrine of informed consent' into the English law. Citing both *Sidaway* and *Bolitho*, it was observed that:

> If there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of doctor to inform the patient of the significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.

The Apex Court of Australia has also started moving away from the *Bolam test* and has started accepting the concept of informed consent. It observed, in *Rogers* v. *Whitaker,*[26] that the question whether the patient has been given all relevant information to choose between undergoing and not undergoing the treatment does not depend on medical standard or practices. This is a question for the court to decide and the duty of deciding it cannot be delegated to any professional or group in the community. The Canadian courts are also following the reasonable patient approach.[27]

It was well establish that consent which is not properly informed, is not real consent. Once the patient had been informed, in broad terms, of the nature of intended treatment/procedure and had given his consent, the patient cannot state that there was a lack of real consent.[28]

Recently, a three judges bench of the Supreme Court of India, awarded a compensation of Rs.25,000 and waiver of surgery fees to a women whose uterus was removed by a lady obstetrician without her consent.[29] The question before the court was whether a surgeon can legally perform one operation after taking consent for another. It was alleged that the patient was admitted to a private hospital for 'diagnostic and operative laparoscopy, but instead a 'hysterectomy (removal of uterus) and bilateral salpingo-oopherectomy'(removal of fallopian tubes) was performed, rendering her incapable of bearing any children in the future.

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[25] (1998) 48 BMLR 118.

[26] (1992) 109 ALR 625.

[27] *White* v. *Turner*, (1981) 120 DLR (3d) 269.

[28] *Chatterton* v. *Gerson*, (1981) QB432.

[29] *Samira Kohli* v. *Prabha Manchanda*, (2008) 2 SCC 1.

Completely forbidding additional surgery without consent from the patient, the Court summarized the various aspects of consent in the following words:

(1) A doctor has to seek and secure the consent of the patient before commencing a 'treatment" (the term "treatment" includes surgery also). The consent so obtained should be real and valid, which means that: the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what he is consenting to.

(2) The 'adequate information" to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment or not. This means that the doctor should disclose (a) nature and procedure of the treatment and its purpose, benefits and effect; (b) alternatives if any available; (c) an outline of the substantial risks; and (d) adverse consequences of refusing treatment. But there is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment which may persuade a patient to undergo a fanciful or unnecessary treatment. A balence should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.

(3) Consent given only for a diagnostic procedure, cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment procedure. The fact that the unauthorized additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault

and battery. The only exception to this rule is where the additional procedure though unauthorized, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorized procedure until patient regains consciousness and takes a decision.

(4) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

(5) The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in *Canterbury* but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field. It will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment.

(iv) Error of judgment

Error of judgment on the part of a doctor (e.g. wrongful diagnosis, wrong treatment) would tantamount to negligence if it is an error which would not have been made by a reasonably competent professional medical man acting with ordinary care. Very often, in a claim for compensation arising out of medical negligence, a plea is taken that it is a case of bona fide mistake. This may be excusable under certain circumstances but a mistake which would tantamount to negligence will not be pardoned.

In the case of *Whitehouse* v. *Jordan*[30] an obstetrician had pulled too hard in a trial of forceps delivery and had thereby caused the plaintiff's head to become wedged with consequent asphyxia and brain damage. The House of Lords held that the obstetrician was guilty of negligence. The court observed:

> The true position is that an error of judgment may or may not be negligent; it depends on the nature of the error. If it is the one that

[30] (1981) 1 All ER 267.

would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant holds himself out as having and acting with ordinary care then it is negligence. If on the other hand, it is an error that such a man, acting with ordinary care might have made then it is not negligence.

In *M/S Spring Meadows Hospital* v. *Harjot Ahluwalia*[31] the Supreme Court observed that gross medical mistake would always result in a finding of negligence. Use of wrong drug or wrong gas during the course of aneasthetic will frequently lead to the imposition of liability and in some situations even the principle of *res ipsa loquitur* can be applied. Even delegation of responsibility to another may amount to negligence in certain circumstances. A consultant can be negligent where he delegates the responsibility to his junior with the knowledge that the junior was incapable of performing his duties properly.

In *Achutrao Haribhau Khodwa* v. *State of Maharashtra*[32] a mop was left inside the lady patient's abdomen during an operation. Peritonitis developed which led to a second surgery being performed on her, but she could not survive. Liability for negligence was fastened on the surgeon because no valid explanation was forthcoming for the mop having been left inside the abdomen of the lady.

In *Laxman Balkrishna Joshi's*[33] case the death of the patient was caused due to shock resulting from reduction of the fracture attempted by the doctor without taking the elementary precaution of giving anaesthesia to the patient. The doctor was held guilty of negligence and liable to pay damages.

In *Vinitha Ashok* v. *Lakshmi Hospital*[34] removal of pregnancy was done without ultrasonography and uterus of the patient had to be removed. There was expert evidence to indicate that ultrasonography would not have established ectopic pregnancy but some text books indicated otherwise. The general practice in the area in which the doctor practiced

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[31] AIR 1998 SC 1801.

[32] AIR 1996 SC 2377.

[33] *Supra* n. 3.

[34] AIR 2001 SC 3914.

was not to have ultrasonography done. Therefore no negligence was attributed on this ground even if two views could be possible.

In *Dr. P.N. Rao* v. *G. Jayaprakasu*[35] a very promising young boy of 17 was admitted in a government hospital for removal of tonsils. As a result of the negligence in the administration of anaesthesia during the operation, the patient became victim of cerebral anoxia making him dependant on his parents. The anesthetist, the surgeon and the government were all held liable for damages to the plaintiff.

When an injection meant for intramuscular use was administered as an injection intravenous in a government hospital resulting in death of the patient, the government was held liable in public law for damages under Article 226 of the constitution[36].

In *Nizam's Institute of Medical Sciences* v. *Prasanth S. Dhananka*[37], the complainant who was then an engineering student suffered from recurring fever. The X ray examination revealed a tumour in left hemithorax with erosion of ribs and vertebra. Even then without having MRI or Myelography done, cardiothoracic surgeon excised the tumour and found vertebral body eroded. Operation resulted in acute paraplegia of the complainant. MRI or Myelography at the pre-operation stage would have shown necessity of a neurosurgeon at the time of operation and the paraplegia perhaps avoided. Consent was not taken for removal of tumour but only for excision biopsy. The hospital and the surgeon were held liable for negligence.

Thus, a doctor who is charged with negligence can absolve himself from liability if he can prove that he acted in accordance with the general and approved practice. He will be held liable only if the judgment is so palpably wrong as to imply an absence of reasonable skill and care on his part.

D. Consumer Protection Act, 1986

Civil courts have been entertaining complaints of medical negligence from patients or their representatives and have been awarding compensation/

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[35] AIR 1990 AP 207.

[36] *Bholi Devi* v. *State of J&K*, AIR 2002 SC 65.

[37] (2009) 6 SCC 1.

damages to them for the injury suffered by them. However, the procedure in civil proceedings is tardy, expensive and time-consuming. Because of this, many of the aggrieved consumers stayed away from the ordinary courts and suffered in silence. Complainants who went to the courts for relief generally had to wait for years to get justice and that too after spending heavily on advocates and towards court fees. The procedure is also cumbersome and time-consuming making litigation costly and troublesome for ordinary person who constitute the majority of the population. The Consumer Protection Act, 1986 was enacted to remedy this situation by providing a simple, inexpensive and expeditious mechanism for redressing the genuine grievances of consumers of goods and services.

After the Consumer Protection Act, 1986 came into force, some of the consumer courts in various states started receiving complaints from patients or their representatives regarding deficiency in service on the part of hospitals and doctors. The complainants generally argued, *inter alia*, that: (i) the patients who paid for the services of doctors/hospitals/ nursing home are consumers as defined in the Act; (ii) the definition of the expression 'service' under the Act that "service means service of any description which is made available to potential users" is wide enough to cover services rendered by hospitals and doctors also; and (iii) the Act provides for payment of compensation to the consumers (patients) for the injury suffered by the consumer due to the negligence of the opposite party (doctors/hospitals).

The doctors/hospitals on the other hand argued, *inter alia*, that: (i) the services rendered by the medical professionals are specifically excluded from the purview of the Act as the exclusive part of the definition specifically excludes 'the service rendered under a contract of personal service' and that the services rendered by them are under a contract of personal service; and (ii) the consumer courts (the District Forum, the State and National Commission) are not competent to judge the issue of negligence in connection with medical services as they are not a body of professionals having expertise in medical services.

These arguments along with a lot of other issues were taken up before the apex court by the Indian Medical Association for a final decision. The Supreme Court in a landmark judgment delivered in *Indian Medical*

Association v. *V.P. Shantha*[38] clarified the various points raised before it. The court upheld the constitutional validity of the Consumer Protection Act and held that doctors/hospitals and nursing homes fell within the scope of the Act as the services rendered by them including the rendering of consultation, diagnosis and treatment – both medical and surgical – would come under the definition of service under the Act. However, where a doctor or hospital renders service free of charge to every patient or under a contract of personal service, a patient availing of such free services will not be a consumer.

The landmark judgment of Apex Court in *Laxman Thamappa Kotgiri* v. *G.M. Central Railway*[39] has given the railway employees the right of consumers while availing treatment in a railway hospital free of cost. Similarly, the beneficiaries of ESI Corporation[40] and CGHS[41] were also received the right to sue the doctors working in ESI hospital and CGHS approved hospitals and dispensaries even if the treatment is free of cost. This is in stark contrast to earlier judgments wherein free treatment was considered outside the purview of Consumer Protection Act.

IV. CRIMINAL LIABILITY FOR MEDICAL NEGLIGENCE

A criminal liability arises when it is proved that the doctor has committed an act or made omission that is grossly rash or grossly negligent which is the proximate, direct or substantive cause of patient's death. Under Section 304 A of the Indian Penal Code, a doctor is punishable for criminal negligence[42]. This offence is cognizable, bailable and non-compoundable. It is cognizable in the sense that the offender can be arrested by a police officer without warrant. However, the police officer cannot act unreasonably as he is required to take an objective decision on the basis of either reasonable suspicion or credible information. It is a bailable offence and as such the doctor who is arrested is entitled to be released on bail as a matter of right. It is non-compoundable in the sense that the offence can not be compounded by compromise between the suspected

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[38] *Supra* n. 1.

[39] (2007) 4 SCC 596.

[40] *Kishore Lal* v. *Chairman*, ESIC, (2007) 4 SCC 579.

[41] *Jagdish Kumar Bajpai* v. *Union of India*, 2007 MLR 175 (NC).

[42] Under this section, "whoever causes the death of any person by doing any rash or negligent act amounting to culpable homicide is punishable with imprisonment for a term that may extend up to two years or with fine or with both."

offender and the victim or his representative. Other provisions in the Indian Penal Code which may be invoked are Section 337 (rash or negligent act resulting in simple hurt) and Section 338 (rash or negligent act resulting in grievous hurt).

Criminal liability may also arise under a number of other statutes such as the Indian Medical Council Act, 1956, the Dentists Act, 1948, the Medical Termination of Pregnancy Act, 1971, the Preconception and Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, the Transplantation of Human Organs Act, 1994 and other penal laws enacted by the Parliament and State legislatures from time to time.

However, criminal law has invariably placed the medical professionals on a pedestal different from ordinary mortals. The Indian Penal Code sets out a few vocal examples. Section 88 in the Chapter on General Exceptions provides exemption for acts not intended to cause death, done by consent in good faith for person's benefit. Section 92 provides for exemption for acts done in good faith for the benefit of a person without his consent though the acts cause harm to a person and that person has not consented to suffer such harm. Section 93 saves from criminality certain communications made in good faith.

The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of *mens rea* must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.[43]

The law relating to criminal negligence was laid down by Straight J., in the case of *Reg* v. *Idu Beg,*[44] where the court said that criminal negligence is the gross and culpable neglect or failure to exercise that reasonable and proper care and precaution to guard against injury either to the public generally or to an individual in particular, which having regard

[43] *Supra* n. 6.

[44] 1881 (1) 3 All 776.

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

The court in *R.* v. *Prentice & Sullman*[45] and *R.* v. *Adomoko*[46] has settled the law as to how to determine criminal negligence in medical practice as :

a) Indifference to an obvious risk of injury to health;

b) Actual foresight of the risk coupled with the determination nevertheless to run it;

c) An appreciation of the risk coupled with an intention to avoid it, but the attempted avoidance involves a very high degree of negligence;

d) Inattention to a serious risk which goes beyond "mere inadvertence" in respect of an obvious and important matter which the doctor's duty demanded, he should address.

In *John Oni Akirele* v. *King*[47] case a duly qualified medical practitioner gave to his patient the injection of sobita which consisted of Sodium Bismuth Tartrate as given in the British Pharmacopeia. However, what was administered was an overdose of Sobita. The patient died. The doctor was accused of manslaughter, reckless and negligent act. He was convicted. Their Lordships quashed the conviction on a review of judicial opinion and an illuminating discussion on criminal negligence. What their Lordships have held can be summed up as under:

(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 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 it that appellation.

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[45] (1993) 4 Med LR 304.

[46] (1994) 3 All ER 79 (HL).

[47] AIR 1943 PC 72.

There is a difference in kind between the negligence which gives the right to compensation and the negligence which is a crime.

(iii) It is impossible to define culpable or criminal negligence, and it is not possible to make the distinction between actionable negligence and criminal negligence intelligible except by means of illustrations drawn from actual judicial opinion. The most favourable view of the conduct of an accused medical man has to be taken, for it would be most fatal to the efficiency of the medical profession if no one could administer medicine without a halter round his neck.

Their Lordships refused to accept the view that criminal negligence was proved merely because a number of persons were made gravely ill after receiving an injection of Sobita from the appellant coupled with a finding that a high degree of care was not exercised. Their Lordships also refused to agree with the thought that merely because too strong a mixture was dispensed once and a number of persons were made gravely ill, criminal degree of negligence was proved.

In *Dr. Krishna Prasad* v. *State of Karnataka*[48] case the patient was admitted for a delivery in a nursing home. The doctor decided caesarian operation under spinal anesthesia. The blood pressure began to fall soon after administering spinal anesthesia and ultimately the patient died. The criminal proceeding against the anesthetist was started on the allegation that he was not an anesthetic expert and that the test dose of spinal xylocaine injection was not given to the patient. The Court quashed the criminal proceeding on the ground that the doctor holding degrees like MBBS, FRCs and DGO is qualified to administer anesthesia and that the omission to give test dose does not amount to rashness or negligence.

Where a Kaviraj who was not a qualified surgeon cut the internal piles of a patient by an ordinary knife in consequence of which the patient died of haemorrhage, Kaviraj was convicted under section 304A IPC for his rash and negligent act. His plea for the benefit of Section 88 IPC saying that what he did was in good faith and he had obtained the consent of the patient and in the past had performed several operations of the same type was unacceptable to the court.[49]

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[48] (1970) 3 SCC 904.

[49] *Sukaroo Kaviraj* v. *Emperor*, ILR (1887) Cal 566.

Another similar case is that of *Dr. Khusal Das Pamman Das* v. *State of M.P.*[50] where it was held that the fact that a person totally ignorant of science of medicine or practice of surgery undertakes a treatment or performs an operation is very material in showing his gross ignorance from which an inference about his gross rashness and negligence in undertaking the treatment can be inferred. In this case the accused, a Hakim, not educated in allopathic treatment and having no idea about the precautions to be taken before administering the injection and effects of the procane penicillin injection, gave it to the deceased. This act was taken to be clearly rash and negligent within the meaning of Section 304A of IPC 1860.

In *Jaggankhan* v. *State of M.P.*[51], a homeopathic doctor gave to his patient who was suffering from guinea worms, twenty-four drops of stramonium and a leaf of datura without contemplating the reaction such a medicine could cause, resulting in the death of the patient. The doctor was held guilty of criminal negligence.

In *Poonam Verma* v. *Ashwin Patel*[52] a registered medical practitioner in homeopathy was held guilty of negligence *per se* for prescribing allopathic medicines to a patient resulting in her death, the court ordered the Medical Council of India and the State Medical Council to consider the feasibility of initiating appropriate action under Section 15(3) of the Indian Medical Council Act, 1956 for practicing allopathic system of medicine without possessing the requisite qualifications.

The Supreme Court in *Dr. Suresh Gupta* v. *Govt. of NCT*[53] has declared that 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." The court, in this case, held:

> Where a patient dies due to the negligent medical treatment of the doctor, the doctor can be made liable in civil law for paying compensation and damages in tort and at the same time, if the degree of negligence is so gross and his act was so reckless as to

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[50] AIR 1960 MP 50.
[51] (1965) 1 SCR 14.
[52] (1996) 4 SCC 332.
[53] (2004) 6 SCC 422.

endanger the life of the patient, he would also be made criminally liable for offence under Section 304-A IPC.

In this case, the patient was operated by the appellant plastic surgeon for removing his nasal deformity resulting in the death of the patient. It was alleged that the death was due to 'asphyxia resulting blockage of respiratory passage by aspirated blood consequent upon surgically incised margin of nasal septum'. The cause of the death was found to be not introducing a cuffed endo-tracheal tube of proper size so as to prevent aspiration of blood from the wound in the respiratory passage. The court held that the carelessness or want of due attention and skill alleged in this case cannot be described to be so reckless or grossly negligent as to attract criminal liability.

The principle laid down in *Dr. Suresh Gupta* has been upheld in *Jacob Mathew* v. *State of Punjab*[54], where the court observed:

> To prosecute a medical professional for negligence under criminal law, it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

As an illustration, the court said that a doctor who administers a medicine known to or used in a particular branch of medical profession impliedly declares that he has knowledge of that branch of science and if he does not, in fact, posses that knowledge, he is *prima facie* acting with rashness and negligence.

In this case, it was contended by the complainant that the death of his father has occurred due to the carelessness of doctors and nurses and non-availability of oxygen cylinder and also because of the fixing up of an empty cylinder on his mouth due to which his breathing had totally stopped.

Rejecting the charge of criminal negligence, the court held that the averments made in the complaint, even if held to be proved, did not

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[54] *Supra* n. 6.

make out a case of criminal rashness or negligence on the part of the accused appellant. The court further observed:

> It is not the case of the complainant that the accused appellant was not a doctor qualified to treat the patient whom he agreed to treat. It is a case of non-availability of oxygen cylinder either because of the hospital having failed to keep available a gas cylinder or because of the gas cylinder being found empty. Then, probably the hospital may be liable in civil law or may be not, but the accused-appellant cannot be proceeded against under S. 304-A IPC.[55]

The Court issued the following guidelines which should govern the prosecution of doctors in future:

(i) A private complaint may not 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.

(ii) The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission obtain an independent and competent medical opinion preferably from a doctor in government service, qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying the *Bolam test* to the facts collected in the investigation.

(iii) A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been levelled against him). Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest may be withheld.[56]

In *Dr. Saroja Dharampal Patil* v. *State of Maharashtra*[57], a pregnant woman was taken to the hospital of the applicant where she

[55] *Id.*, para 53.
[56] *Id.*, para 52.
[57] Manu/MH/1263/2010.

delivered a child by a normal delivery through vertex. The applicant noticed that patient was bleeding profusely after the placenta had come out. Since, inspite of immediate treatment, the bleeding could not be stopped, she was shifted to another hospital. There also the prognosis continued and the flow of bleeding could not be controlled inspite of medical treatment. She died ultimately due to inversion of the uterus. The father of the deceased gave statement to the police that he had no grievance against anyone about the death of his daughter. After two day, however, he lodged an FIR alleging that deceased died as a result of negligence of the applicant while treating her. The applicant sought quashing of the chargesheet filed in pursuance of the said FIR.

The investigating officer obtained the opinion of the independent medical authority which purports to show that the applicant was duly trained for conducting delivery and, therefore, was competent to undertake the work of conducting delivery of deceased, gave necessary treatment to the patient while conducting the delivery, medicines administered to the patient were proper and correct treatment was given and there was no undue delay committed by the applicant in referring the patient to obtain treatment at the higher centre when the haemorrhagic flow could not be stopped inspite of immediate treatment. The court after stating the general principles relating to medical negligence as laid down in *Jacob Mathew* v. *State of Punjab,*[58] and reiterated in *Kusum Sharma* v. *Batra Hospital and Medical Research Centre*[59] explained the rule for holding medical practitioner liable and held that no medical negligence was committed by the applicant.

In *Dr. Renu Jain* v. *Savitri Devi,*[60] the complainant became pregnant after six years of sterilization operation. She alleged that the applicant assured the complainant that latest technologies were available in her Nursing Home and she was specialist of surgery of sterilization. Taking cognizance of her complaint, the applicant was summoned under Sections 337, 420, 467, 471 of IPC. Applicant approached the court for quashing that proceeding. She pleaded that it might be a case of failure of the operation but since there was no material to show that there was any

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[58] *Supra* n. 6.

[59] *Supra* n. 19.

[60] Manu/UP/1242/2010.

negligence on her part in conducting the surgery for which she was qualified, she cannot be blamed. Further that there was no evidence of cheating or any false assurance. The court held that the applicant is not liable for prosecution as no evidence or expert opinion by any other competent doctor was produced against her, which was made mandatory by the Supreme Court in *Jacob Mathew's* case.

In *Dr. Shivanand Doddamani* v. *State of Karnataka*[61], a complaint was filed against the doctors of the District Hospital Dharwad. Complainant pleaded that his brother sustained injuries to his thigh in a road mishap and was admitted to the District Hospital. Doctors failed to provide any treatment to him which resulted in his death after four days. Magistrate issued summons and charged the doctors for the offence under section 304-A of Indian Penal Code. The impugned order was assailed by the doctors before the High Court mainly on the ground that the statement in the complaint did not make out any *prima facie* case to show that the doctors were guilty of negligence of higher degree as laid down by the Apex Court in the case of *Jacob Mathew* and the guidelines laid down in that case for initiating action against the medical officer were totally flauted by the Magistrate. Dismissing the claim of the doctors, the Court held that guidelines of the Apex Court when applied to the facts in question will make out a *prima facie* case. The allegation was that the patient died due to treatment not been provided by the doctors. The doctors had 'duty' to treat the patient who was admitted to the hospital, not treating him is 'breach of duty' and 'death' being the ultimate result due to breach of duty, negligence of higher degree is noticeable.

The Supreme Court has been pragmatic and considerate in dealing with the criminal liability of the medical practitioners for medical negligence, but not in the least lenient as some of the medical practitioners might like to believe. In its latest judgments the Hon'ble Supreme Court has not only erected safeguards against indiscriminate prosecution of physicians but has also impressed upon the need for taking certain precautions by the physicians/Hospitals while treating patients. The physicians must also rise to the occasion by assuming greater responsibility and imbibing greater public confidence.

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[61] 2010 (3) KCCR 1832.

V. PROOF OF NEGLIGENCE

Medical negligence is easy to allege, but extremely difficult to prove. The general rule is that the burden of proving negligence as a cause of the accident lies on the party who alleges it. For establishing negligence or deficiency in service there must be sufficient evidence that a doctor or hospital has not taken reasonable care while treating the patient. Reasonable care in discharge of duties by the hospital and doctors varies from case to case, and expertise expected on the subject, which a doctor or a hospital has undertaken. Courts would be slow in attributing negligence on the part of the doctor if he has performed his duties to the best of his ability with due care and caution. It is the duty of the redressal agencies to safeguard the interests of the patients against malpractices by medical professionals but at the same time, the inexpensive nature of consumer jurisdiction should not be allowed to become a vicious weapon in the hands of unscrupulous patient to harass the medical professionals without good and adequate cause.

A. Burden of Proof

It is for the patient complainant to establish his claim against the medical man and not for the medical man to prove that he acted with sufficient care and skill. If the initial burden of negligence is discharged by the claimant, it would be for the hospital and the doctor concerned to substantiate their defence that there was no negligence.

The complainant must allege specific act of negligence and prove how that amounts to negligence. He has to allege which action of the opposite parties was not as per accepted medical practices. This has to be supported by expert evidence or medical literature on the subject. Mere allegation of negligence will not make out a case of negligence, unless it is proved by reliable evidence and is supported by expert evidence.[62]

B. The Requirement of Expert Testimony

Serious questions of medical negligence against professionals cannot be decided by suspicion or discrepancies. In the absence of expert evidence supporting the allegations of the complainant, the complaint is liable to be dismissed.

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[62] *Vimlesh Dixit* v. *Dr. R.K. Singhal,* 2004 (9) CLD 257 (Uttaranchal); *K.S. Bhatia* v. *Jeevan Hospital,* 2004 CTJ 175 (NC) (CP).

The plaintiff in a medical negligence action is ordinarily required to produce, in support of his claim, the testimony of qualified medical experts. This is true, because the technical aspects of his claim will ordinarily be far beyond the competence of the judges. The plaintiff, himself a layman in most instances, is not free simply to enter the courtroom, announce under oath that the defendant surgeon amputated his leg instead of saving it, and then request the court to find the surgeon negligent. The judges possessing no special expertise in the relevant field, are incapable of judging whether the facts described by the plaintiff, even assuming an accurate narration by him, add upto negligent conduct. And the plaintiff himself is incompetent to supply guidance; he too lacks the training and experience that would qualify him to characterize the defendant's conduct.

A charge of negligence affects the professional status and reputation of a doctor. Therefore the burden of proof on the part of the complainant alleging negligence of the doctor is correspondingly greater. A finding not based on any expert evidence cannot be sustained.

A complaint alleging negligence by mishandling of needle biopsy as the needle pierce the blood vessel of the patient resulting in death, is dismissed by the National Commission on the grounds that the complainant neither filed any report of a doctor to substantiate the averments made in the complaint nor produced any medical literature in support of the allegations. Thus, there was no evidence on record of any negligence in the procedure adopted for needle biopsy except the bald allegations of the complainants.[63]

The Supreme Court in *Indian Medical Association* v. *V.P. Shantha*[64] observed that medical negligence on the part of doctor is to be proved as a fact by leading evidence which may be of an expert. In *Dr. S Gurunathan v. Vijaya Health Centry*[65], National Commission held that in the absence of expert evidence on behalf of the complainant, the commission is held justified in relying upon the affidavit filed by the doctors on behalf of the hospital in a case of medical negligence. In *Amar Singh v. Frances Newton Hospital*[66], it was held that all medical negligence

[63] *O. Aisha B* v. *J.R. Danial*, 2004 CTJ 31 (CP) (NC).

[64] *Supra* n. 1.

[65] (2003) 1 CPR 222.

[66] (2000) 1 CPJ 8.

cases concern various questions of fact, when the burden of proving negligence lies on the complainant, it means he has the task of convincing the court that his version of the facts is the correct one.[67]

In a medical negligence lawsuit the plaintiff must put qualified medical experts on the witness stand to testify (1) that plaintiff suffered an injury that produced the disability and other ill effects claimed by him; (2) that the cause of this injury, or at least a significant contributing cause of it, was the professional services rendered by the (defendant) doctor; (3) that the standard methods, procedures, and treatments in cases such as plaintiff's were such and such; and (4) that defendant's professional conduct towards plaintiff fell below or otherwise unjustifiably departed from the described standard.

(i) Relevance of Expert Evidence

The role of the expert medical witness is to inform the judge so as to guide him to the correct conclusions. It must be for the judge to guess the weight and usefulness of such assistance as he is given and to reach his own conclusions accordingly.

An expert witness in a given case normally discharges two functions. The first duty of an expert is to explain technical issues as clearly as possible so that it can be understood by a common man. The other function is to assist the Court in deciding whether the acts or omissions of medical practitioners or the hospital constitute negligence. In doing so, the expert can throw considerable light on the current state of knowledge in medical science at the time when the patient was treated. In most of the cases, the question whether a medical practitioner or hospital is negligent or not, is a mixed question of fact and law and the Courts are not bound in every case to accept the opinion of expert witness. Although in many cases the opinion of the expert witness may assist the Court to decide the controversy one way or the other.

The real function of the expert is to put before the court all the materials, together with reasons which induce him to came to the conclusion,

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[67] *G. Sampanti* v. *Hindustan Aeronautics Limited & Anr.*, 2005 (3) CPJ 369 (Kar); *O. Aisha B.* v. *Prof. JR Danial*, 2004 CTJ 31 (CP) (NC); *Indian Medical Association* v. *V.P. Shantha, supra* n.1.

so that the court, although not an expert, may form its own judgment by its own observation of those materials. An expert is not a witness of fact and his evidence is really of an advisory character.

(ii) *Criteria for condemning expert evidence*

The principle of law enunciated by the House of Lords[68] is that a doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his conduct where it had not been demonstrated to the judge's satisfaction that the body of opinion relied on was reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field were of a particular opinion would demonstrate the reasonableness of that opinion. However, in a rare case, if it could be demonstrated that the professional opinion was not capable of withstanding logical analysis, the judge would be entitled to hold that the body of opinion was not reasonable or responsible. The judge has the right to come to the conclusion that the views genuinely held by a competent medical expert are unreasonable when he is satisfied that the body of expert opinion cannot be logically supported at all and that such opinion will not provide the bench mark by reference to which the defendant doctor's conduct falls to be assessed. Recently, the Supreme Court has also expressed the same view in *Malay Kumar Ganguly* v. *Sukumar Mukherjee*.[69]

(iii) *Conflicting expert evidence – duty of court*

In cases of conflicting expert evidence what the judge has to decide is which of the two explanations (of the experts) is to be preferred. That is a question of fact which the judge has to determine on the ordinary basis on a balance of probability. It is a question for the judge to weigh up the evidence of both sides, and he is entitled in a situation to prefer the evidence of one experts witness to that of the other. Judge is the expert of all experts.

In a large number of cases complaints were dismissed as the complainants could not adduce expert evidence to prove medical negligence.

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[68] *Bolitho* v. *City and Hackney Health Authority*, (1994) 4 All ER 771 (HL).

[69] *Supra* n. 16.

(iv) *Is expert opinion essential in every case*

Ever since medical professionals have been brought under the ambit of Consumer Protection Act, there is a rise in the number of unnecessary, frivolous and even malicious litigation harming medical fraternity.

In the light of this, the Supreme Court in *Martin F D'Souza* v. *Mohd. Ishfaq*[70] has directed the consumer forum to first seek an expert opinion from a panel of doctors whether any *prima facie* case is made out against the doctor or not, and only thereafter send notice to the medical practitioner. This was thought necessary to avoid harassment to doctors who may not be ultimately found to be negligent. However, recently Supreme Court in *V. Kishan Rao* v. *Nikhil Super Speciality Hospital*[71] held that expert opinion of *prima facie* negligence is not a precondition for consumer forum to proceed with the case. Expert opinion is required only when a case is complicated enough warranting expert opinion, or facts of a case are such that forum cannot resolve an issue without expert assistance. It was further held that direction given in *Jacob Mathew*[72], for consulting another doctor before proceeding with criminal investigation was confined only in cases of criminal complain and not in respect of cases before the consumer forum.[73]

In *V. Kishan Rao* v. *Nikhil Super Speciality Hospital*,[74] the appellant got his wife admitted to Respondent 1 Hospital on 20-7-2002 as the wife was complaining of intermittent fever and chills. The wife did not respond to the treatment given by Respondent 1 Hospital for typhoid, rather her condition deteriorated. On 24-7-2002, when her condition became extremely critical (no pulse, no BP and pupils dilated), she was removed to Yashoda Hospital where certain tests were conducted and efforts were made to revive her but she expired on 24-7-2002 itself. It was alleged that when the patient was admitted in the Yashoda hospital, the copy of the hematology report dated 24-7-2002 disclosed blood smear for malaria parasite whereas Widal test showed negative. Respondent 1 Hospital has not given any treatment for malaria. The appellate filed a

[70] (2009) 3 SCC 1.

[71] *Supra* n. 17.

[72] *Supra* n. 6.

[73] *Supra* n. 17.

[74] *Ibid.*

case for medical negligence against Respondent 1 Hospital. The District Consumer Forum without seeking help of an expert, on the fact of the case itself, awarded compensation of Rs. 2 lakhs plus refund of Rs. 10,000. The State Commission allowed the appeal of Respondent 1 Hospital saying that in the fact and circumstances in the case complainant failed to establish any negligence on the part of the Hospital and there is also no expert opinion to state that the line of treatment adopted by the Hospital is wrong or is negligent. The National Commission dismissed the appellant's appeal. The appellant then approached the Supreme Court.

Allowing the appeal, the Supreme Court held that expert evidence was not necessary to prove medical negligence in every case. Expert opinion is required only when a case is complicated enough warranting expert opinion, or facts of a case are such that forum cannot resolve an issue without expert's assistance. Each case has to be judged on it's own facts. The Court held that the purpose of the Consumer Protection Act is to provide a forum for speedy and simple redressal of consumer disputes. Such legislative purpose cannot be defeated or diluted by superimposing requirement of having expert evidence in cases of civil medical negligence, regardless of factual position of a case. If that is done efficacy of Act would be curtailed and in many cases remedy would become illusory for common man.

On the facts it was held that where a patient who was suffering from intermittent fever and chills, was wrongly treated for typhoid instead of malaria for four days, which resulted in her death, was an apparent case of medical negligence. It was not necessary to obtain expert opinion in the first instance before District Forum could award compensation. As investigation conducted by another Hospital where the patient was removed in a critical condition showed that Widal Test for Typhoid was negative whereas test for malaria was positive, it was sufficient for District Forum to conclude that it was a case of wrong treatment.

The Court observed that before forming an opinion that expert evidence is necessary, the forum under the Act must come to a conclusion that the case is complicated enough to require opinion of an expert or that facts of the case are such that it cannot be resolved by members of the forum without the assistance of expert opinion. Each case has to be judged on its own facts. If a decision is taken that in all cases medical negligence has to be proved on the basis of expert evidence, in that event,

efficacy of remedy provided under the Consumer Protection Act will be unnecessarily burdened and in many cases such remedy would be illusory. If any of the parties before the Consumer Forum wants to adduce expert evidence, members of the forum by applying their mind to the facts and circumstances of the case and materials on record can allow the parties to adduce such evidence if it is appropriate to do so in the facts of the case. The discretion in this matter is left to the members of the forum and there cannot be a mechanical or straitjacket approach that each and every case must be referred to experts for evidence.

The Court is of the opinion that the present case is not a case of complicated surgery or a case of transplant of limbs and organs in human body. It is a case of wrong treatment in as much as the patient was not treated for malaria even when the complaint was of intermittent fever and chill.

C. *Res ipsa loquitor*

Res ipsa loquitor is no more than a convenient label to describe situations where, notwithstanding the plaintiff's inability to establish the exact cause of the accident, the fact of the accident by itself is sufficient, in the absence of an explanation, to justify the conclusion that most probably the defendant was negligent and that his negligence caused the injury. The general purport of the words *res ipsa loquitor* is that the accident speaks for itself or tells its own story. The normal rule is that it is for the plaintiff to prove negligence, but in some cases considerable hardship is caused to the plaintiff as the true cause of the accident is not known to him, but is solely within the knowledge of the defendant who caused it, the plaintiff can prove the accident but cannot prove how it happened to establish negligence on the part of the defendant. This hardship is sought to be avoided by invoking the principle of *res ipsa loquitor*[75]. Where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendant, that the accident arose from want of care.

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[75] *Pushpabai Parshottam Udeshi* v. *M/s Ranjit Ginning & Pressing Co. Pvt. Ltd.*, AIR 1977 SC 1735.

The maxim comes into operation : (a) on proof of the happening of an unexplained occurrence ; (b) when the occurrence is one, which would not have happened in the ordinary course of things without negligence on the part of somebody other than the plaintiff, and (c) the circumstances point to the negligence in question being that of the defendant, rather than that of any other person.

Some of the examples are amputation of wrong limb or wrong digit at operation, burning of skin caused by strong antiseptic solution, leaving swabs or surgical instrument inside the patient after the operation.

The onus lies on the doctors in the operation theatre to explain events and the ultimate outcome, i.e., the death of the patient[76]. When keratotomy operation was performed on left eye of a teenager in violation of accepted professional practice, resulting in loss of his eyesight, the burden of proof is on the doctor to establish that he was not in breach of any duty in giving treatment to the minor patient.[77]. The onus of proof shifts upon the attending doctors to prove that there was no negligence in performance of operation when the patient died within 10 hours of admission in the operation theatre in mysterious circumstances[78]. Where the complainant is not aware of what took place inside the operation theatre, the onus of proof lies on the doctor to establish that there was no negligence on his part resulting in permanent disability of the patient[79].

In *Bhanupal* v. *Dr. Prakash Padode*[80] it was observed that the patient's relatives must prove positive act of omission but they need not produce evidence to establish the standard of care if the entire operative procedure was carried out in the absence of any of the patient's relatives. Naturally, when all such medical or surgical procedure was carried out inside the operation theatre when nobody on behalf of the patient was present, the patient's relatives were unable to see any kind of medical / surgical procedure or what exactly happened inside the operation theatre. Therefore, the opposite parties and the staff attending inside only had

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[76] *Arunaben D. Kothari* v. *Navdeep Clinic,* 1996 (3) CPR 20 (Guj).

[77] *Adarsh Bararia* v. *Dr. P.S. Hardias,* 2002(2) CPR 188 (Bhopal).

[78] *Bhanupal* v. *Dr. Prakash Padode,* II(2002) CPJ 384 (Bhopal).

[79] *S.A. Qureshi* v. *Padode Memorial Hospital and Research Hospital,* II (2000) CPJ 463 (Bhopal).

[80] *Supra* n. 78.

special knowledge of what happened inside the operation theatre and the complainant is not in a position to exactly state the factual aspects of whatever took place inside. Therefore, it was a duty cast upon the surgeon to prove the fact that no sort of negligence took place inside the operation theatre. Thus, the onus of proof shifts upon the opposite parties to substantiate the fact that there was no negligence on their part.

In *Nadiya* v. *Proprietor, Fathima Hospital*[81] the complainant approached the opposite party hospital for surgery for increasing the height. She underwent Corticotomy with external fixator. However, after the surgery, her left leg remained 1 ½ inch shorter than the right leg. She needed the aid of walker as she had to lean on the left. It was contended by the hospital that the complications suffered by the complainant resulted due to her failure to adhere to the instructions of the doctors. It was held that the burden shifted to the opposite parties to substantiate their case.

In *Mahon* v. *Osberne*[82] a majority of the court of appeal considered that the doctrine of *rês ipsa loquitor* applied. Goddard L.J. said :

> The surgeon is in command of the operation, it's for him to decide what instruments, swabs and the like are to be used, and it's he who used them. The patient, or, if he dies his representatives, can know nothing about this matter.
>
> There can be no possible question but that neither swabs nor instruments are ordinarily left in the patient's body and no one would venture to say that it's proper, although in particular circumstances it may be excusable, so to leave them.
>
> If, therefore a swab is left in the patient's body after an operation, it seems to be clear that the surgeon is called for an explanation.

The Supreme Court applied the doctrine of *res ipsa loquitor* in *Achutrao's* case[83] where the patient had to undergo second operation in critical condition for removal of a mop (towel) left inside the peritoneal cavity of the patient during sterilization operation in a Government hospital. The High Court of Rajasthan[84] also invoked the doctrine of *res ipsa loquitor*

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[81] (2001) II CPJ 93.

[82] (1939) 2 KB 14.

[83] *Achutrao Haribhau Khodwa* v. *State of Maharashtra,* (1996)2 SCC 634.

[84] *Rajmal* v. *State of Rajasthan,* 1996 ACJ 1166.

to hold the State Government liable for the death of a patient during laparoscopic tubectomy operation in the Government hospital. The State Commission, Karnataka[85] held the dental surgeon liable in negligence for slipping of needle into the stomach of the patient at the time of irrigation the mouth after extraction of right molar teeth of the patient by applying the principle of *res ipsa loquitor,* as the surgeon could not explain as to why the needle was detached from the syringe while irrigation the mouth of the patient.

The Supreme Court in *Savita Garg* v. *The Director, National Heart Institute*[86] held that once evidence is placed by the complainant to satisfy that the patient admitted for treatment after taking him to intensive care unit developed jaundice and died because of lack of proper care and negligence, then the burden shifts to the hospital and the doctor who treated the patient to satisfy that there was no negligence on the part of doctor or hospital. It would be too much of a burden on the patient or the family members to undertake search enquiry from the hospital to ascertain the names of treating doctors or the staff and to show who was responsible for the death. The hospital is in better position to disclose what care was taken or what medicine was administered to the patient.

Recently, the Supreme Court held that in a case where negligence is evident the principle of *res ipsa loquitor* operates and the complainant does not have to prove anything as the thing (res) proves itself. In such a case it is for the respondent to prove that he has taken care and done his duty to repel the charge of negligence.[87]

However, mere failure of sterilization operation, without proof of negligence, in itself is not actionable by invoking the principle of *res ipsa loquitor* as the methods of sterilization so far known to medical science which are most prevalent and popular are not 100 percent safe and secure.[88]

VI. Conclusion

Medicine is a science which has many probabilities and possibilities. The human body is not a laboratory to produce the same result every

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[85] *Ambalappa* v. *Sriman D. Veerendra Heggade,* 1999(3) CPR 72 (Bangalore).

[86] 2004 CTJ 1009 (SC).

[87] *Supra* n. 17.

[88] *State of Punjab* v. *Shiv Ram*, (2005) 7 SCC 1.

time. Diseases also vary in their course and complications. There is a growing awareness among people in the recent years about medical negligence. In view of this a number of complaints (both civil and criminal) have been filed against the medical practitioners and hospital managements. A survey of cases in the area of medical negligence reveals the conflicting views expressed by the judiciary while defining the standard of medical care to be followed by the doctors and hospitals in the treatment of patients.

Under the *Bolam test* determining the standard was seen by the courts as essentially a matter for the medical profession, to be resolved by expert testimony with minimal court scrutiny. In recent years, courts have become more willing to probe such testimony and challenge the credibility of medical expert, although they would very rarely override clinical judgments. *Bolitho* may be constructed as inviting courts to reach their own conclusions on the reasonableness of clinical conduct, along standard risk-benefit lines, after having made their own assessment of the expert opinion.

Medical negligence litigation is related to errors in medical practice which should never occur if the basic rules of clinical management are followed, clinical information is accurately recorded and analyzed, and there is appropriate communication with patients. Informed consent is a process which depends absolutely on the communication between the doctor and the patient. A well informed patient is less likely to sue a medical professional in case of unfavourable outcome as compared to a less informed one.

Medical practice has always had a place of honour in society. The reality today, however, is that the doctor-patient relationship has deteriorated to a great extend and the number of medical negligence lawsuits is increasing very fast. Consumerism in the medical field is well established in India. Medical indemnity insurance premium is rising at a rapid rate and the cost is ultimately passed on to the patients. Besides this, defensive medicine is very well established in India. Currently the balance between service and business is shifting disturbingly towards business and this calls for improved and effective regulation whether internal or external. There is need for introspection by doctors individually and collectively. They must rise to the occasion and enforce discipline and high standards in the profession by assuring an active role.

Medical practitioners need to have sympathy for patients, take care of the sick and show concern for their suffering; otherwise, the profession will lose its respect. They need to remember the ethical imperatives propounded by Hippocrates, Father of medicine, choosing the least costly route and the least troublesome investigations, always keeping patient welfare in mind.

The doctors should learn all the legal aspects of their profession. It should be the duty of both the medical and legal fraternity to teach and update medical professionals on law that governs the issues related to medical negligence. The law of medical negligence is indispensable if the right to life is not to be a fleeting breath imperilled by a physician's flaw, surgeon's knife, anaesthetist's indifference or equipment inadequacy.[89]

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[89] V.R. Krishna Iyer, *Book Review* of R.K. Bag, LAW OF MEDICAL NEGLIGENCE AND COMPENSATION (2nd ed., 2001).