CIVIL LIABILITY FOR DEFICIENCY IN MEDICAL SERVICES WITH SPECIAL REFERENCE TO SURGICAL TREATMENTS: A CRITIQUE OF CONSUMER PROTECTION ACT, 1986

By

SUNITHA K.K

COLLEGE OF LEGAL STUDIES

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Under the guidance of

Prof. (Dr.) Tabrez Ahmad

Director, College of Legal Studies

&

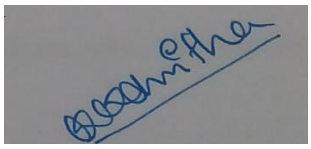
Dr.Anil G Variath

Senior Law Consultant

Law Focus, Mumbai

DECLARATION

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which has been accepted for the award of any other degree or diploma of the university or other institute of higher learning, except where due acknowledgment has been made in the text.



SUNITHA. K.K

SAP ID 500033563

UNIVERSITY OF PETROLEUM AND ENERGY STUDIES
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This is to certify that this thesis entitled "**CIVIL LIABILITY FOR DEFICIENCY IN MEDICAL SERVICES WITH SPECIAL REFERENCE TO SURGICAL TREATMENTS: A CRITIQUE OF CONSUMER PROTECTION ACT, 1986**" by **SUNITHA K.K (SAP.ID 500033563)**.in partial completion of the requirement for the award of Degree of Doctor of Philosophy (Law) is an original research work carried out by her under my supervision and guidance.

It is certified that this work has not been submitted anywhere else for the award of any other diploma or degree of this or any other University.

Internal Guide

08/11/2016

Prof. (Dr.) Tabrez Ahmad
Director
College of Legal Studies

HOLI CAMPUS Energy Acres, PO Bidholi Via Prem Nagar, Dehradun 248007 (UK), INDIA, T +91-135-2102690/1, 2694201/3/8 F +91-135-2694204
NDOLI CAMPUS Knowledge Acres, Vill. Kandoli, PO Bidholi Via Premnagar, Dehradun 248007 (UK), INDIA, T +91-135-2102647/2102760
RPORATE OFFICE 2nd Floor, 210, Okhla Industrial Estate, Phase III, New Delhi-110020, INDIA, T +91-11-41730151-53 F +91-11-41730154

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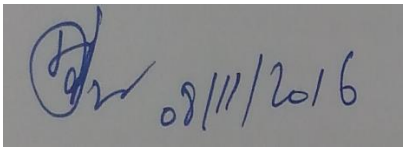

Prof. (Dr.) Tabrez Ahmad

Director

College of Legal Studies

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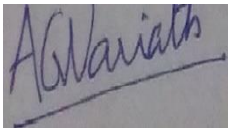

Dr. Anil G. Variath

Senior Law Consultant

Law Focus, Mumbai

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Sunitha K.K

Dedication

To my Elder Brother

Sri.K.K.Ramachandran

EXECUTIVE SUMMARY

Availability of legal remedies and access to justice are crucial in protection of rights generally, and particularly in addressing grievances of health and safety. With the opening up of economy and rapid advancement in technology, consumer has become more vulnerable. This vulnerability is absolute in health sector. This is a study on civil liability for deficiency in medical services with special reference to surgical treatment under general law and specifically under the provisions of Consumer Protection Act. A detailed study on vitiated consent and informed consent is attempted. An analysis of remedies available under general law and COPRA is specifically attempted as well. This study aims to suggest legal reforms through a comprehensive analysis of Consumer Protection Act, 1986.

Health sector is booming as an industry in India. Along with that, cases of medical negligence are also increasing in number and extent. A patient, as a consumer is in a peculiar position. The medical terminology and technology is beyond the understanding for majority Indians. He is emotionally delicate, even if he is as empowered as the doctor, socially. Over and above, the innovative marketing strategies complicate the situation making him more and more powerless. Consumer Protection is one of the major concerns of twenty-first century and its implementation through enforcement of consumer rights is an accepted approach internationally.

In all the earlier civilizations Medical Negligence was treated as a crime. The objective of legal machinery was to protect and vindicate the interest of public by punishing the wrong doer. No amount of compensation used to be awarded to the victims or their people. However as society progressed, the trend to consider negligence as a Tort (civil wrong) influenced judiciary and a practice of giving compensation to the victim has developed. Unlike the intentional Torts like, assault, battery and false imprisonment, Negligence which is an unintentional Tort, is relatively a modern legal development. During British rule, English common law was introduced in the administration of justice in

India. Prior to the introduction of Constitution of India in 1950, a very large number of English legal principles were followed and applied by the Indian Courts. The trend is followed till date.

The general law of professional negligence is applicable to medical profession also. It is expected that the practitioner must bring to his task, a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of particular circumstances of each case. If he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, he is not liable, even though a body of adverse opinion also existed among medical men.

In India, the Supreme Court has held, in several decisions, that a doctor is not liable for negligence or medical deficiency if some wrong is caused in her/ his treatment or in her/ his diagnosis if she/ he has acted in accordance with the practice accepted as proper by a reasonable body of medical professionals skilled in that particular art, though the result may be wrong. In various kinds of medical and surgical treatment, the likelihood of an accident leading to death cannot be ruled out. It is implied that a patient willingly takes such a risk as part of the doctor-patient relationship.

Surgery is a medical treatment in which a doctor cuts into someone's body in order to repair or remove damaged or diseased parts. It is a profession defined by its authority to cure by means of bodily invasion. Every surgical operation is fraught with risk. No operation can be considered to be safe as any complication, during the operation may appear any time. No two human bodies are exactly alike. Each has its own deviation and distinctive features. Human bodies are as individual and different in their details as are human beings. In number of decisions various courts, have made candid explanations in respect of liability of doctors and hospital while performing a surgery.

Law of Tort is that branch of law which enables the victim of a wrong to seek remedy from the person who injured her. Unlike a criminal case, which is

initiated and managed by the state, a tort suit is prosecuted by the victim or the victim's estate. A successful suit results in a judgment of liability, rather than a sentence of punishment. In other words, it requires the defendant to compensate the plaintiff financially.

Negligence means omission to do something which a reasonable man, guided by those ordinary considerations which ordinarily regulate the conduct of human affairs, would do or the doing of something which a reasonable and prudent man would not do. Negligence is not 'neglect or carelessness'. But it is the failure to take such care as required in the particular context.

The fundamental idea behind liability for negligence is the duty of care. Professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. The Supreme Court of India has settled law that medical professional can be held liable for negligence if, he has not possessed of the requisite skill which he professed to have possessed and (or) he did not exercise with reasonable competence in the given case, the skill, which he did possess. The standard to be applied for judging whether the professional is negligent or not would be that of an ordinary competent person exercising ordinary skill in that profession.

Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised and exercised with reasonable degree of care and caution. He does not assure his client of the result. A lawyer does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on. The only assurance which such a professional can

give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practicing and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is what the entire person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of 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. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practices. The burden of proof of negligence, carelessness, or insufficiency generally lies with the complainant. The law requires a higher standard of evidence than otherwise, to support an allegation of negligence against a doctor. In cases of medical negligence the patient must establish her/ his claim against the doctor. The complainant has to prove the presence of duty of care, breach of care and the consequential damages suffered by him.

A doctor's duty of reasonable care involves giving the patient, a description of his conditions and appropriate course treatment including the risks. If there is a probability of the treatment producing results, which are harmful to patient, those factors must be weighed by the doctor, before he recommends the treatment. The patient is entitled to consider and reject the treatment.

US legal system insisted on 'informed consent' from the patient's point view as essential pre-requisite of medical intervention, while UK, for a long time maintained that 'real consent' from doctor's perspective is enough as settled by the Bolam Decision in 1957.

The Indian Supreme Court, following that principle, held that, 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 (informed

consent) 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.

However, the Bolam Test is out of use and it was established that informed consent is now part of English law. Courts in Australia, Malaysia, New Zealand, Ireland, and Canada, following common law system have legal system requiring informed consent from the patient's point of view. For medical practice to be effective there should be concordance between the doctor and patient. This being a fiduciary relationship has its foundation well laid in mutual trust and candour. The doctor is no longer 'God' and patient the blind devotee. Social dimensions are changing and corresponding changes are required in legal system as well.

Earlier, the patients aggrieved by medical negligence did not have any effective adjudicative body for getting their grievances redressed. The Indian Medical Council Act, 1956 as amended in 1964, provides for regulation of medical education .The medical Council is reconstituted under the Act for registration of medical practitioners.The Indian Medical Council (Professional conduct, etiquette and ethics) Regulation, 2002 specify regulations, whose violations shall constitute misconduct. Disciplinary action will be taken against the erring doctors on the basis of a complaint and enquiry by peer group. The Council was available only at the state headquarters, thereby making it hardly accessible to the majority of parties. Further, the Council has no power to award compensation to the patients for the injury sustained.

Consumer movement in India had its roots in the early part of 20th century in India. The Consumer Protection Act was enacted in 1986 to protect the interests of consumers. It is one of the most comprehensive and progressive piece of social welfare legislation. Unlike other laws, which are basically punitive or preventive in nature, the provisions of the Act are compensatory. The Act is intended to provide simple, speedy and inexpensive redressal to the consumers'

grievances. It also provides relief of a specific nature and awards compensation, wherever appropriate.. The Act provides for exclusive three tier redressal machinery as an alternative to the civil court and other legal remedies available in the country.

Before the enactment of Consumer Protection Act in 1986, the injured party in case of medical negligence had only two options available, either to approach the civil court under law of Tort or the High Court under its writ jurisdiction. Both are proved to be tedious, time taking and expensive for common man. The Consumer Protection Act, 1986 (COPRA) was enacted 'to provide for better protection of the interests of the consumers'. The legislation, has the unique distinction of being the only one in the country made exclusively for consumers to protect their interests against defective goods and deficient services, even though a plethora of existing legislations do have provisions to deal with consumer rights in different degrees on specified matters. The provisions of the Act are in addition to and not in derogation of the provisions of any other law for the time being in force.

The critical question that whether a medical practitioner can be regarded as rendering 'service' under Section 2(1)(o) of the Consumer Protection Act, 1986 was specifically answered in positive and has been settled by the landmark judgment of the Supreme Court in the case of Indian Medical Association v. VP Shantha & others. And thereafter in number of decisions, Supreme Court, various High Courts and Consumer fora have settled the law in this regard.

COPRA gives protection against deficiency in service. It is available in case of medical service too. As far as surgical treatment is concerned, the National Commission in 1998 observed that inadequate preparation for surgery is deficiency in service. It also includes adopting procedures which are not for the benefit of the patient but safeguard against the possibility of the patient making a claim of negligence. It is the duty of the surgeon to ensure full recovery and rehabilitation. Post-operative care plays a major role in this. Not complying with the very high standards of critical care required in the ICCU is clearly deficiency

in service. Similarly surgeon is required to give and the hospital should provide along with discharge certificate, the instructions for post-operative care. In comparison with the similar laws enacted by other countries, no law matches Indian law as this magnificent piece of legislation works for better protection of interest of consumers at large. This is the first statute brought on the statute book after UN General Assembly passed the resolution calling upon all developing nations to save consumers from exploitation from unscrupulous and unfair trade practices. But when it comes to medical negligence, it has no universal application. As it is only available to consumer, a large section of Indian population is left out of its protection. The adjudicatory forums which are conceived as speedier alternative to Civil Courts have become another form of the latter. Poor Indian consumers still keep themselves distant from medical litigations not because of absence of negligence but because of the sheer expenditure involved and the uncertain end in such cases. Legislative intervention is urgently needed in this respect.

As far as medical negligence is concerned COPRA is proved to be the best available legal solution. The Consumer Fora provides expeditious, informal and inexpensive remedy. However, the experience with this quasi-judicial forum is not perfectly satisfactory. Complaints are increasing in number about, inordinate delay, lack of expert knowledge, and invariable presence of advocates and inefficient or non-functioning of forums in many cases. Further, the protection under Consumer Protection Act is available only to consumers and the beneficiaries of public healthcare system and free services are under outside its purview. This is a serious infirmity. A comprehensive legislation which will extend its protection to all type of patients with specific adjudicatory mechanism is needed.

There is no difference in principle applied to the assessment of damages in a medical negligence case from other actions for personal injuries. In case of death due to medical negligence, the valuable life is abruptly terminated. The medical man is bound to compensate the family of the deceased patient whose death is caused by his wrongful act, neglect or default. While fixing an amount

of compensation payable to a victim of an accident, the damages have to be assessed separately as pecuniary damages and special damages. Pecuniary damages are those which the victim has actually incurred and which is capable of being calculated in terms of money; whereas non-pecuniary damages are those which are incapable of being assessed by arithmetical calculations. Pecuniary damages may include expenses incurred by the claimant: (i) medical attendance; (ii) loss of earning of profit up to the date of trial; (iii) other material loss. So far non-pecuniary damages are concerned, they may include (i) damages for mental and physical shock, pain suffering, already suffered or likely to be suffered in future; (ii) damages to compensate for the loss of amenities of life which may include a variety of matters i.e. on account of injury the claimant may not be able to walk run or sit; (iii) damages for the loss of expectation of life, i.e. on account of injury the normal longevity of the person concerned is shortened; (iv) inconvenience, hardship, discomfort, disappointment frustration and mental stress in life.

The Award of compensation by Consumer Redressal Agencies are guided by well-recognized legal principles related to quantification of damages. These Fora are duty bound to award compensation on a rational basis. The extent of injury suffered and the monetary loss incurred are assessed on the basis of materials produced before the forum. The loss is ascertained by balancing various factors. Section 14(1) of the Consumer Protection Act, 1986 deals with calculation of amount of compensation**.** Under this section, compensation is payable to the consumer for loss or injury suffered due to negligence of the opposite party.However,the large majority of Indian population still has no accessibility to the protection of COPRA, 1986.The medical services provided by Government hospital are out of the purview of Consumer Protection. Establishment and working of Consumer Fora is influenced by the Human right atmosphere-social, economic, educational disparities. Lack of awareness about the Consumer Rights is major hurdle in implementation of this magnificent piece of legislation. Major attempts are required to create awareness among the population about Consumer Rights.

Function of the law is to lay down certain standards of conduct which the community is expected to observe since without the observation of such standards civilised life could not be carried on satisfactorily. It is essential that the damages awarded in the medical negligence cases gives the right message to the medical community that' tort does not pay' irrespective of the social status of the victim. In setting that lies the protection of patients in India. In order to ensure consistency and uniformity, award of compensation needs to have clear and certain standards.

Comprehensive legislation, in the lines of Motor Vehicles Act, 1988, exclusively dealing with medical negligence is an urgent need. The Thesis is having a specific suggestion to enact new law and establish a new set of adjudicatory mechanism which will be free from the infirmities of COPRA.

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- The Uttarakhand Prohibition of Violence Against Medicare Service Personnel And Damage To Property In Medicare Service Institutions Bill , 2013

ABBREVIATIONS

- COPRA Consumer Protection Act
- IPC Indian Penal Code
- AIR All India Reporter
- SCC Supreme Court Cases
- CPJ Consumer Protection Journal
- NCDRC National Consumer Dispute Redressal Commission
- NC National Commission
- SCDRC State Consumer Dispute Redressal Commission
- MLJ Madras Law Journal
- SCR Supreme Court Report
- KB King's Bench
- SC Supreme Court
- CPC Consumer Protection Cases
- MP Madhya Pradesh
- AP Andhra Pradesh
- Cri LJ Criminal Law Journal
- PIL Public Interest Litigation
- All ER All England Reports
- Mad Madras
- CLT Civil Laws Times
- SLT Supreme Laws Today
- ACTSC Australian Capital Territory Supreme Court
- EWCA Civ England and Wales Court of Appeal Civil
- EWHC England and Wales High Court
- UKSC United Kingdom Supreme Court
- Lah Lahore
- CGSI Consumer Guidance Society of India

CHAPTER I INTRODUCTION

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The patient is not just a group of symptoms, damaged organs and altered emotions. The patient is a human being, at the same time worried and hopeful, who is searching for relief, help and trust[1].

Patient is rightly termed as the most delicate consumer as the world of medicine and therapy is alien to him. Medical negligence cases are increasing in number and are causing irreparable damage to their physical and mental well-being.

Legal approach to medical interference has undergone an attitudinal change concomitant to social development. There is a growing awareness regarding patient's rights. This trend is clear from the spurt in medical negligence litigations. The Indian Supreme Court has endeavoured painstaking efforts to constitutionalize right to health as a fundamental right[2].The patient-centred initiative of rights protection is critical in the economic context of the rapid decline of state spending and massive private investment in the sphere of the health care system.

1.1 RIGHT TO HEALTH AND HEALTH CARE

India is a member of UN since the time of proclamation of Universal Declaration of Human Rights (UDHR) in 1945 and was a party to it. The spirit of Indian Constitution indicates the influence of this International legal instrument. Most of the Civil and Political rights are guaranteed as Fundamental Rights .The Constitution makes a forceful appeal to the state through Directive Principles of State Policy to work towards assuring the Economic, Social and Cultural Rights[3].

Health and Health care are Human Rights. This is reflected in the provision for "right to highest attainable standard of physical and mental health' of the

[1] Kaba R, Sooriakumaran P. *The evolution of the doctor-patient relationship*, International Journal of Surgery 57, 5 (2007).
[2] Paschim Banga Khet Mazdoor Samiti v.State of West Bengal (1996)4 SCC37, Parmanand Katara v. Union of India AIR 1989 SC 2039 etc.
[3] RAVI DUGGAL,*Right to health and Healthcare, Theoretical Perspectives* , HEALTH CARE CASE LAWS IN INDIA 1-16 (MIHIR DESAI & KAMAYANI MAHABAL ed. 2007)

International Covenant on Economic, Social and Cultural Rights [4] .The Constitution of India guarantees 'Right to Life' as the fundamental right of the citizen. It states, "No person shall be deprived of his life or personal liberty except through procedure established by law"[5]

Till 1970s, the courts, by and large interpreted "life" literally. A change was visible in the judicial approach, lately. Over the years, it has come to be accepted that life not only means animal existence, but the life of a human being with all its concomitant attributes. This would include a healthy environment and effective health care facilities[6].

Part 4 of Indian Constitution prescribes Directive principles of State Policy. These are the guiding principle for states while enacting laws and implementing policies. The obligation of the state to provide health care facilities is set out in the Part 4.

In one of the earlier cases of Public Interest Litigation in *Muncipal Council, Ratlam v. Vardhichand & Ors*[7], the Supreme Court observed that, "The State will realize that Article 47 makes it a paramount principle of governance that steps are to be taken for the improvement of public health as amongst its primary duties."[8]

In *CESC Ltd v. Subash Chandra Bose*[9], the Supreme Court, referring to various International instruments concluded that right to health is a fundamental right.

In *CERC v. Union of India*[10], while dealing with a PIL for the protection of the health of the workers engaged in mines and asbestos industries, the apex Court stated that:

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[4]Article 12 of International Covenant on Economic, Social, Cultural Rights. http://nhrc.nic.in/documents/International%20Covenant%20on%20Economic%20Social%20and%20Cultural%20Rights.pdf Last visited on 27-04-2016 at 11.52 a.m
[5] Article 21 of the Indian Constitution
[6] supra note 3 at 17-35
[7] 1980 Cri LJ 1075
[8] supra note 3 at 17-35
[9] AIR 1992 SC 573
[10] 1995 AIR 922, 1995 SCC (3) 42

> It would thus be clear that in an appropriate case, the Court would give appropriate directions to the employer, be it the State or its undertaking or-private employer to make the right to life meaningful; to prevent pollution of work place; protection of the environment; protection of the health of the workman or to preserve free and unpolluted water for the safety and health of the people. The authorities or even private persons or industry are bound by the directions issued by this Court under Article 32 and Article 142 of the Constitution.

1.2 MEDICAL NEGLIGENCE

Negligence is the failure to take due care, as a result of which one causes injury to another. Carelessness becomes a ground for legal liability only in cases where there is a duty to take care. Medical Profession is one of such segments where duty to be diligent is imposed in the strictest sense. A medical practitioner is expected to have a particular degree of skill and knowledge and he is also expected to be careful in using that skill and knowledge. It is not enough that he acted in goodfaith. He is expected to use the requisite degree of due care[11].The legal position regarding the standard of care is set in Common law[12] that a doctor is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. The Supreme Court of India has settled law in this regard in 2004[13].

> A medical professional may be held liable for negligence if, he has not possessed of the requisite skill which he professed to have possessed and (or) he did not exercise with reasonable competence in the given case, the skill, which he did possess. The standard to be applied for judging whether the professional is negligent or not would be that of an ordinary competent person exercising ordinary skill in that profession.

With increasing privatization of the health care sector and gradual withdrawal of state from it, the role and obligations of private sector becomes more and more significant. In ordinary circumstances, private medical practitioner or a private hospital, has a right to decide, whether to undertake a case or not.however,Medical Council of India in its affidavit filed before the Supreme Court[14],stated that though doctors are not bound to treat every case, they cannot

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[11] supra note 3 at 71-86
[12] Bolam v.Friern Hospital Management Committee 1957 2 All ER 118
[13] Jacob Mathew v. State of Punjab (2005) 6 SCC 1
[14] Parmanand Katara v. Union of India AIR 1989 SC 2039

refuse an emergency case on humanitarian grounds and the noble tradition of the profession necessitates this[15].Indian courts have held that in emergencies neither government nor private doctors can insist on payment of money before dealing with the patient. In *Parvat Kumar Mukerjee v. Ruby General Hospital*[16], the National Commission held that, in emergencies the doctor is bound to treat and cannot insist on delaying the treatment until the fees were paid.

1.3 CIVIL LIABILITY AND DEFICIENCY IN MEDICAL SERVICE

There are two kinds of civil remedies. Public law and private law remedy. Private law remedy involves action under Torts or Contract. In public law remedy, the claim is against the state for a wrong committed by it or persons acting under it.Both exist independent of each other. If there is a medical negligence by a doctor in a government hospital, writ jurisdiction of the SC or HC can be invoked. At the same time the injured party can also seek civil law remedy under Torts, contract against individuals before civil courts or consumer fora.

The civil liability in negligence cases are by and large covered by the judge made common law under law of Torts. The Indian law on negligence is highly influenced by this part of common law .The trend remained the same over decades with few changes, here and there[17].

The Supreme Court held in Laxman Joshi's[18] case that, when the medical practitioner gives treatment or advice, he impliedly undertakes that he is possessed of skill and knowledge for that porpose.And in executing his duty he must employ a reasonable skill, knowledge and care.Therfore, the medical practitioner will be bound by liability in the absence of any of the two. In an action for medical negligence the injured party has to prove, not only that, he has suffered injury but it is the result of the negligence of the doctor[19].

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[15] supra note 3 at 37-45
[16] Original Petition No 90 of 2002, decided by NCDRC on 25th April 2005.
[17] supra note 3 at 71-86
[18] Laxman Balkrishna Joshi v. Trimbak Bapu Godbole AIR 1969 SC 128
[19] Philips India Ltd. v. Kunju Punnu 1975 M. L.J. 792

In some circumstances, however, negligence can be attributed even though there is no direct nexus between injury and conduct of medical practitioner. In *Poonam Verma*'s case[20],the act of a homeopathic doctor prescribing allopathic medicine was held to be '*negligence per se*'.Similarly in cases where the doctrine of '*res ipsa loquitur*' is applied,in the absence of a justifiable reason from the defendant, it is assumed that the accident occurred due to the want of care from the defendant.

1.4 LIABILITY UNDER CONSUMER PROTECTION ACT,1986

In case of medical negligence, an injured party can claim compensation either through a civil suit or a complaint lodged under consumer Protection Act (COPRA),1986.After the enactment of this legislation, there has been a wide spread debate as to whether the Act is applicable to medical services or not? Wide ranging issues from the applicability of the Act to medical practitioners, the nature of medical services which would be covered, nature of consumers etc. have been litigated. The Supreme Court finally set at rest the controversy in the case of *Indian Medical Association v V.P.Shantha*[21].The Court held that proceedings under COPRA are summary proceedings for speedy redressal and the remedies are in addition to private law remedy. Therefore, it cannot be denied to a patient who is suffering from deficiency in medical service.[22]

Since then, there has been a significant rise in the medical negligence cases being filed under COPRA[23]. However, there are practical difficulties as far as Indian patients are concerned- political, social and also legal –which hurdles the delivery of justice.

It is attempted in this study to critically analyse the provisions of Consumer Protection Act, 1986 to scrutinise Civil Liability for Deficiency in Medical Services with Special reference to Surgical Treatment.

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[20] Poonam Verma v. Aswin Patel (1996) 4 SCC 332
[21] (1995) 6 SCC 651
[22] supra note 3 at 71-86
[23] supra note 3 at 72-87

1.5 RATIONALE OF THE STUDY

- Consumer Protection is one of the major concerns of twenty-first century due to the increasing invasion of market economy all around the globe.
- Consumer Protection through enforcement of consumer rights is an accepted approach internationally and concern over patient's rights is gathering momentum.
- A patient, as a consumer is most delicate, due to the special situation.
- The number of Medical Negligence cases reported, especially that of Surgical Treatments increases abysmally.
- Health Sector is a booming industry in India.
- The medical terminology and technology is beyond the understanding of an average patient. Along with this the innovative marketing strategies complicates the situation and makes him more and more powerless.
- Consumer Protection Act, 1986, being the prominent legislation in this area, need to be revisited. Its enforce mechanism needs to be studied for suggesting possible changes to invigorate the legal system so as to promote welfare needs.

1.6 OBJECTIVES OF THE STUDY

- To examine the provisions in Law of Torts and other legislations like, Indian Medical Council Act,1956 and Clinical Establishment etc., so as to develop clear picture on the current status of civil liability for deficiency in medical services.
- To scrutinise the legal position and significance of Consent and Informed Consent with respect to surgical treatments in India
- To analyse the effectiveness of Consumer Protection Act 1986, in fixing liability for Deficiency in Medical Services.
- To study principles and practice with regards to Remedies available, Burden of Proof and Calculation of Damages in case of Deficiency in Service by medical professional generally and specifically with respect to Surgical Treatments.
- To highlight the judicial approach in this area.

1.7 RESEARCH PROBLEM

Enumerable cases are reported of medical negligence relating to surgical treatments causing irreparable damage to physical and mental well- being of human beings. Patient is rightly termed as the most delicate consumer. In the current situation, obtaining consent of patient prior to surgical treatment is a farce. Being a professional misconduct, liability in this case is difficult to prove for an average patient. Therefore available remedies become a far cry. Even with respect to calculation of damages for pain, suffering, emotional disturbances and loss followed by such deficiency in services, there are no concrete standards under the Act.

Under this background a critical analysis of implementation of Consumer Protection Act 1986 in this specific area is essential to find out and incorporate effective legal measures to ensure right to health and wellbeing of citizen through this legislation.

Though there are several studies on Consumer Rights specifically and Consumer Protection generally, there is no study which focuses only on Civil Liability for Deficiency in Medical Services,especially in Surgical treatments under Consumer Protection Act, 1986. Therefore, this study fills the gap.

1.8 REVIEW OF LITERATURE

To study the Civil Liability for Deficiency in Medical Services and its implications in Consumer Protection Act, and also to identify the areas already investigated, the researcher has referred to important studies already undertaken on Consumer Protection and Medical Negligence**.** These references were helpful in formulation of hypothesis.

- RAMAKANT TIWARI &MAHESH DABHADE, in the book titled, "Current issues in Social Sciences", address the issues in Social Science in 21st century .The book identifies and analyses those issues in the light of globalized economy and the changing paradigm, consequential changes in lifestyle, work culture,

family, interpersonal relations etc. Seventh chapter of this book identifies consumer as an issue of the millennium and the coming decades. The chapter contains a general study of the problems faced by consumer, changes in consumer behaviour, and the concept of Consumer Rights for Consumer Protection.

- AVTAR SINGH'S book, "Law of Consumer Protection" has explained the basic concepts and definitions as used in the Consumer Protection Act of 1986 in general terms. This book analyses different fields of consumer goods and service s, subject-wise, depending upon the decisions delivered by the State and National Commissions. The author has discussed in detail the applicability of the Consumer Protection Act, 1986 to various services like airlines, banking, housing, insurance, posts and telegraphs and telecommunications.
- R.K.BANGIA'S, "Consumer Protection Laws and Procedures" is a comprehensive study on various Consumer Protection laws and Procedure in India.
- NIRAJ KUMAR, in his book "Consumer Protection In India" has made a detailed study about Consumer Protection in India, starting from origin, movement, legislation and its functioning.
- R.N.P CHAUDHARY'S book, "Consumer Protection Law : Provisions and Procedure, contains a critical commentary on the Consumer Protection Act,1986.The Consumer Protection (Amendment) Act ,2002 has been widely discussed. The sixth chapter contains a detailed discussion on other laws related to Consumer Protection. The book covers all significant developments in the field of Consumer Laws. Towards the end, the book contains some clear and precise guidelines for protection to the consumer.
- CHEENA GAMBHIR in the book, "Consumer Protection Administration, Organization and working" makes an in depth study, on the working of the Consumer Protection Act, 1986 and the redressal mechanism under the Act. The book analyses the functioning of Consumer Protection Councils and redressal agencies with special reference to Chandigarh.

- SABA NIZAMI has edited the book titled, "Consumer Rights :Perspective and Experiences" which is a collection of relevant, authoritative and thought provoking articles written by experts in the field and published in research journals. The book focuses on issues, perspectives and experiences of consumer rights and brings to light some aspects of consumer responsibility. There are three sections to this book. The first section covers issues related to consumer rights and responsibilities. The second section is covering consumer issues in some specific industries and the third section shares various country experiences.
- M.NAZER, edited the book titled "Consumer Rights and Awareness" which is a compilation of scholarly articles on the topic Consumerism and Consumer Awareness. These articles discuss topics range from origin to the development and the current trends in Consumer Protection.
- SURESH MISRA edited the book "Consumer Protection in India: Policies and Case Studies" which is the outcome of a National Seminar on 'Consumer Protection in India: Lessons learnt and Future Challenges' organized by IIPA.The papers contributed by well-known experts discuss some of the most important and critical issues pertaining to Consumer Protection in India. The following Papers were most significant for this research.
    - HIMADRI PHUKAN in the article, "Consumerism and Consumer Protection Act" discusses the concept of consumerism and the philosophy of Consumer Protection Act. The author highlights the working of Consumer Redressal Agencies in this respect.
    - P.V.V. SATYANARAYANA MURTHY in his paper, "Working of Consumer Redressal Agencies" highlights the working of the Consumer Redressal Agencies which have brought the consumer justice delivery System close to the door steps of Indian Consumers. Lack of judicial knowledge on the part of non-judicial members hinders the speed of justice. The paper points out that due to lack of infrastructure, some For a are unable to render speedy justice. The three tier judiciary is totally dependent on Consumer Affairs Ministry for each and every thing including appointment and financial support. The author suggests that it is high time; we made these Agencies more independent.

  - RAMESH KUMAR in the paper title, "Alternative dispute Resolution and Consumer Protection Redressal Machinery" brings to light the drawback of present system of redressal grievance under CPA and opines that, though Consumer Protection Act is a focused legislation with minimum legal and technical procedure, yet the system is not able to provide the consumers, the relief they deserve.
  - G.P PRASAIN in his paper, "Consumerism in Manipur: An overview" describes the status of consumerism in the state of Manipur. This was a rare piece of much required information as studies from North- East India are relatively miniscule in the entire literature in this area.
  - G.C.MATHUR and GAURI MODWEL in the paper, "Strengthening Consumer Movement" have classified Consumer Protection into three elements, that is Protection, Awareness and Education. Authors conclude that Consumer Protection is an amalgamation of awareness and education. It is opined that consumer Protection will be fast and effective if the regulation and procedures are uniform in all the states.
- RAJYALAKSHMI RAO in the book titled, "Consumer is King: Know your Rights and Remedies" discusses in detail the issues related to Consumer Protection in varied areas such as Banking, Insurance, Railway Services, Air services, Unfair Trade Practice and Medical Negligence. Medical Negligence under Consumer Protection Act is analysed through a detailed description of various land mark decisions by the Supreme Court and National Commission. The question of consent and informed consent is clearly explained with a detailed analysis of the Supreme Court decision in this respect. The liability of Doctors and Vicarious liability of hospitals is also discussed in great detail.

Reports

- Economic Survey (2013) conducted by the staff of the economic division of the Department of Economic Affairs in the ministry of Finance echoes the objectives for India's economic progress. It contains chapters on key aspects of the macro economic growth factors such as industry, services, human

development and sustainable development. The survey is analytical document as well as a document recording date and government activities.

- The Implementation Report of UN (2013) is a summary of UN guidelines on Consumer Protection. The report states the objectives, General principles and guidelines for protection of the economic interest of consumers. The report emphasizes on the need for creating awareness among consumers for the effective implementation of these guidelines. The report calls for international Co-operation in this respect.
- The planning commission report (2012) is a vision & mission-strategy plan document for the 12^{th} plan (2012-2017).It covers areas of Consumer Protection, safety, redressal mechanism, price monitoring, consumer education etc. A separate chapter is set aside for planning measures for ensuring product safety. However the report is silent about service safety.
- The Briefing Paper **(**2011**)** prepared by Centre for Consumer Action, Research & Training evaluates the significance of COPRA in tune with Medical Services. The report addresses various issues such as burden of proof, vicarious liability of hospitals, lack of awareness among, consumers etc.

Research papers

- ANURAG K. AGARWAL in his paper titled, "Medical Negligence: Law and Interpretation" examines the concept of negligence in medical profession in the light of interpretation of law by the Supreme Court of India and the idea of the 'reasonable man'. He makes a detailed study on various decisions and concludes his paper by saying; those courts have to depend on the advice of experts in this area heavily, except in cases of blatant violation of protocol and doing things which are considered to be unreasonable and imprudent. The level of subjectivity in such decisions is quite high and the purpose of law to be certain and specific is defeated to a large extent. Recent decisions are a good step in the direction of making this murky area a bit tidy, however, a lot needs to be done by the courts in the shape of clearer judgments so that the layman can benefit.

- DAYASHANKAR TIWARI in his paper titled, "Medical Negligence in India: A Critical Study "analyzes the concept of negligence in medical profession in the light of interpretation of law by the Supreme Court of India. The paper covers the entire range of definitions from negligence to professional and areas such as vicarious liability of hospitals are discussed in detail.
- MICHAEL BOYLAN in the paper titled, "Medical Accidents: Is Honesty the best policy? Time for legal duty of candour?" studies the medical accidents in Ireland which is comparable in Indian back ground. The author identifies the problems arising out of this socio-legal issue and argues that, it is better to accept what went wrong. According to him, imposing a legal duty of candour will bring down both the number and the cost involved in such litigations, benefitting both the patient and the doctor.
- M. SRINIVAS in his research paper titled **"**Medical Negligence and Consumer Rights: Emerging Judicial Trends) analyses the judicial trend in the area of Medical negligence and Consumer Protection. He discusses the gradual change in the attitude of Judiciary from Bolam case to Kishan Rao's Case.
- SWETA S. AGARWAL & SWAPNIL S. AGARWAL in the paper titled, "Medical negligence – Hospital's responsibility" examines patient's right to expect a certain standard of care when he puts himself in the hands of the hospital authority or health care providers. When a hospital fails to uphold this responsibility, the institution may be held liable for causing damage to its patients. The vicarious as well as direct liability for providing health care facilities is carefully 13ilful13u in the light of judicial decisions.
- VIRENDAR PAL SINGH et al, in the Article "Awareness about Consumer Protection Act and Medical Negligence among Private and Government Medical College & Hospital Faculty Members" makes an empirical study on awareness about Consumer Protection Act and medical negligence among the faculty of medical and surgical specialties of Dayanand Medical College & Hospital, Ludhiana and Govt. Medical College & Hospital, Patiala. According to this research paper, awareness regarding COPRA is unsatisfactory among medical practitioners in Private and government

hospital. In comparison surgical specialists are better aware than general practitioners.

- SANTHOSH C. S AND NAWAZ B. in the research paper titled 'Perception of Ethics and Consumer Protection (CPA) among Doctors' is a study conducted among doctors regarding their awareness about Consumer Protection Act,1986.A questionnaire was prepared and one hundred Doctors(Academic Professionals) who wilfully consented to participate were asked to fill their response among the choice given. It was a self-administered, structured questionnaire .The study concluded that awareness levels among medical academic professionals are less about ethics and Consumer Protection Act, 1986.
- P.GURUSWAMY et al, in the research paper titled, "A Study on Consumer Awareness on Consumer Protection Council – A Special Reference to Coimbatore District" analyses the level of awareness and the extent of utilization of Consumer Protection Council. This study concludes that many of the consumers have fear about the Court and Procedures.
- MICHAEL FRAKES AND ANUPAM B. JENA in the paper, "Does Medical Malpractice Law Improve Health Care Quality?" approach this question using direct, clinically validated measures of health care treatment quality. This analysis suggests that medical liability and health care quality is supplementary to each other. They are related and have a long way to go.
- NEIL VIDMAR, in the paper titled, "Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries, and Social Political malpractice" discusses medical malpractice liability, law and procedure in American Civil Law from a limited perspective. The paper involves issues about compensation of patients, ability of the American Tort System to separate meritorious claims from non-meritorious claims, degree to which the threat of lawsuits deters negligent medical errors or causes doctors to engage in defensive medicine etc.
- ANDREW J. OSWALD AND NATTAVUDH POWDTHAVEE, in the paper titled, "Death, Happiness and the Calculation of Compensatory Damages" analyses the current method of calculating non-monetary damages. This

paper studies the mental distress caused by bereavement. The largest emotional losses are from the death of a spouse; the second-worst in severity are the losses from the death of a child; the third-worst is the death of a parent. The paper explores how happiness regression equations might be used in tort cases to calculate compensatory damages for emotional harm and pain-and-suffering.

- MARK GEISTFELD in the paper titled, "Placing a price for Pain and Suffering: A New Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries" argues that pain-and-suffering awards are desirable and proposes a method for calculating nonmonetary injuries. After a thorough survey of the approaches used to compute pain-and-suffering damages, the author demonstrates that full compensation is desirable since eliminating or reducing nonmonetary damage awards would create significant inefficiencies and inequities. Applying economic principles, this article recommends that damages can be assessed from an ex- ante perspective that asks how much a reasonable person would have paid to eliminate the risk that caused the pain-and-suffering injury. The author shows that this methodology is appropriate for all tort cases; that it would yield reasonably accurate results despite data limitations.
- RONEN AVRAHAM in a paper dealing with the same issue, "Putting a price on Pain-and-Suffering Damages: A Critique of the Current Approaches and a Preliminary Proposal for Change" suggests a system of nonbinding age adjusted multipliers after making a detailed analysis of the existing modes of calculation of nonmonetary damages in Tort cases.
- ERIC A. POSNER AND CASS R. SUNSTEIN in the paper "Dollars and Death" makes a comparative analysis of Administrative Regulations and Tort Law dealing matters involving Mortality Risks. According to the author, philosophy of both systems has to be combined to form a middle way since such a method will enhance the social welfare.

- **HYPOTHESES**

The Study titled as "Civil Liability for Deficiency in Medical Services with Special Reference to Surgical Treatments: A Critique of Consumer Protection Act, 1986" will proceed with the following Hypotheses.

- The law and procedure under Consumer Protection Act 1986, is not adequate in fixing Liability for Deficiency in Medical Services in India.

1.9 RESEARCH METHODOLOGY

The study will be based on a doctrinal research. A thorough study of the existing legal provisions, judicial decisions, working of the legislation, legal provision in other countries and their feasibility, is planned. Therefore the method will involve documental analysis, textual analysis and policy analysis in this area. Since judicial decisions in India and abroad constitute an inevitable part of the study, case study method may also be adopted as and when required.

1.10 SCOPE OF THE STUDY

- Availability of legal remedies and access to justice are crucial in protection of rights generally, and particularly in addressing grievances of health and safety. This study aims to reveal not only the obstacles but also the potential of the existing legal framework. A scrutiny of the working of Consumer Protection Act, 1986 might enable discovering more appropriate methods in facing the challenges of welfare of consumers in India.
- With the opening up of economy and rapid advancement in technology, consumer has become more vulnerable. This vulnerability is absolute in health sector. This study aims to suggest legal reforms through a comprehensive analysis of Consumer Protection Act, 1986 and other legislations in this area such as Indian Medical Council Act, 1956 and Clinical Establishments Act, 2010 so as to protect the interest of patients in case of Deficiency in Medical Services.
- The study is expected to explore the area of Contributory Negligence and its implications on the liability for Deficiency in Service. Therefore it may

also come out with precise guidelines on the duties and responsibilities of Patients.

- The Consumer Protection Act was passed in 1986 with high hopes that such legislation will solve almost all grievances of consumers through speedy and expedite redressal forum, However, the experience with this quasi-judicial forum is not perfectly satisfactory. Complaints are increasing about inordinate delay, lack of expert knowledge, and inefficient or non-functioning of forums in many cases. This study aims to bring out methods to implement an efficient consumer redressal mechanism
- Consumer Rights are a far cry, when there is no access to remedy. This study aims to find out methods ensuring consumer, her Right and Might
- Though among Indian states there are extremities in terms of political, economic and human rights atmosphere which can reflect in the enforcement of Consumer Rights also, the study will be analysing the effectiveness of the Act in India, generally.

1.11 PLAN OF CHAPTERS

For the convenience of the study, the thesis is divided in to six chapters. The plan of chapters is as follows.

Chapter-1- Introduction .The chapter introduces law on medical negligence and Consumer Protection Act, 1986.An overview on the current legal position of civil liability for deficiency in medical services. Chapter includes the design of the study.

Chapter-2-Medical negligence Liability under Tort law. The chapter is divided into four units. The first unit introduces the concept of negligence and professional negligence. It is an analytical study into the earlier concept of common law, later developments and the recent trends. The second unit contains a detailed analysis of civil liability for medical negligence under Tort Law in India. The past and present legal scenario is studied through various judicial decisions. It includes an analysis of the legal status in other countries. Third unit is discussing defences available for medical negligence and the fourth unit

is touching upon liability under other legislations in this area such as Indian Medical Council Act, 1956, Clinical Establishments Act, 2010 etc.

Chapter -3 Consent and Informed Consent: Legal Scenario is an in-depth study of the rules relating to, medical consent and its need. The chapter is divided into four units. The first unit discusses consent and informed consent under various laws such as criminal law, contract law and tort law. Second unit is discussing consent in relation to medical negligence and its position in India with case laws. Third unit makes a comparative analysis of medical consent in US, UK and other common law jurisdictions. The last unit is analysing the current legal position in the background of other socio-political factors affecting right to health in India and suggesting changes in law.

Chapter-4 – Deficiency in Medical Services under Consumer Protection Act, 1986 is an analysis of the provisions in the Act and its applicability to Medical Services, with special reference to surgical treatment.

The first unit is studying the significance of COPRA, 1986 in medical negligence by scrutinising definitions and interpretations of terms such as consumer and service under the statute and by the courts. The second unit is about medical negligence under COPRA. It contains a detailed discussion on the extent of the term 'service' and inclusion of medical services under it. Technical aspects such as capability of forum, locus standi, burden of proof etc. are also covered at length. Third unit discusses surgery as method of treatment, its history, legal aspects and liability of surgeon under the Act at various stages of its performance. Chapter will contain an extensive study of judicial decisions in this respect. The Last unit is a comparative study of consumer law in UK and US with that of the Indian statute. This chapter will look in to some of the lacunas of the Act as far as medical negligence is concerned.

Chapter -5- **Remedies** contains an in-depth study of various remedies in case of Deficiency for Medical Services available under civil law with special reference to Consumer Protection Act. The first unit is studying remedies from its philosophical perspective. Purpose of compensation, various theories etc. are covered. Second unit discusses about damages, different principles governing

award of damages under general law, calculation of damages under various heads etc. Third unit studies judge made laws on award of compensation and also the constitutional provisions for remedy for medical negligence. Last unit is about remedies under COPRA and Judicial decisions.

Chapter-6-Conclusion.This chapter contains general and specific observations,and conclusion.The study will contain a bibliography at the end.

CHAPTER II
MEDICAL NEGLIGENCE LIABILITY UNDER TORT LAW

CHAPTER II MEDICAL NEGLIGENCE LIABILITY UNDER TORT LAW

2.1 INTRODUCTION

Law of Tort is that branch of law which enables the victim to seek remedy from the person who injured her.[24].Unlike a criminal case, which is initiated and managed by the state, a tort suit is prosecuted by the victim or the victim's estate.[25] A successful suit results in a judgment of liability, rather than a sentence of punishment. In other words, it requires the defendant to compensate the plaintiff financially. In principle, an award of compensatory damages shifts all of the plaintiff's legally cognizable costs to the defendant.[26] This chapter will be dealing with civil liability for medical negligence under Tort law specifically and other health care legislations generally.

2.2 WHAT IS A TORT?

Tort means wrong. But, it does not concern with all the wrongs that people do. Tort law provides an institutional mechanism for reconciling conflicting claims of people over things that are important to them-freedom of action, bodily security, property and emotional well-being. Fundamental principle of this branch of law is the dutifulness in undertaking various activities not to injure those, whom our undertakings put at risk[27]. In other words,the core value in torts is the duty not to injure others. Thus, while the notion of a wrong remains important, it also addresses the costs, suffering, or more generally, the losses that victims suffer as a result[28]. Tort law distinguishes between two general classes of duties. Duty not to injure and not to injure negligently. In an activity which the law regards as extremely hazardous, there is a duty not to injure. When you engage in more common activities, the duty is not to injure negligently. In general, the conduct is governed by *strict liability* in case of duty

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[24] Peter .M.Gerhart,Tort Law and Social Morality 3-6 (2010)
[25] Coleman,.Jules et al., *Theories of the Common Law of Torts*, The Stanford Encyclopedia of Philosophy Winter Edition,(Edward N. Zalta ed.2015), http://plato.stanford.edu/archives/win2015/entries/tort-theories. Last visited 28-08-2016 at 17.47 p,m
[26] *Id*
[27] *Id*
[28] *Id*

not to injure. It is governed by *fault liability* when you are subject to a duty not to injure negligently or carelessly[29]

2.3 NEGLIGENCE

According to BLACK's law dictionary negligence means "the failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation; any conduct that falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally,wantonly,willfully disregardful of others rights"[30]

In P.R. AIYER's Law Lexicon, it is defined as, "Negligence in its legal acceptance includes acts of omissions as well as commissions" .And "negligence is failure to use the care that a reasonable and prudent person would have used under the same and similar circumstances"[31].

WHARTON'S Law Lexicon[32] suggests that negligence can be a question of law or fact or of mixed fact and law, depending entirely on the nature of a duty, which the person charged with negligence, failed to comply with or perform in the particular circumstance of each case.

WILLES.J opines, "Negligence is a negative word. It is the absence of such care, skill and diligence as it was the duty of the person to bring to the performance of work, which he is said not to have performed[33]".Negligence is omitting to do something which a reasonable man would do or the doing of something which a reasonable man would not do[34]". Negligence as a Tort is a breach of legal duty to take care which results in damage.[35]

In the words of POLLOCK,

> …every tort is an act or omission not being nearly the breach of duty arising out of a personal relation, or undertaken by contract which is

[29] Coleman,.Jules et al., supra note 25
[30] Black's Law Dictionary, 1133-1136(9th.ed. 2009).
[31] Ramanatha Aiyar's The Law Lexicon 1188-1190 (3rd ed.2012)(Shakil Ahmad Khan ed.)
[32] Wharton's Law Lexicon, 1146-1147 (15th ed.2009)
[33] Grill v. General Iron Screw Collier Co,35 LJ cp 330
[34] Blyth v. Birmingham Water works C.,25 LJ Ex 212
[35] W.V.H.Rogers (ed.), Winfield & Jolowicz on Tort, 150-151 (18th ed.2010).

> related in one of the following ways to harm including the interference with an absolute right whether there be measurable actual damage or not suffered by a determinate person.[36]

The word 'tort' is derived from the Latin verb 'tortere' means to hurt. Since the concept of negligence is part of that branch of law, the idea of hurt is an important consideration in establishing negligence.[37]A tort is an act or omission which is unauthorized under law, and independently of contract infringes either some absolute right of another or some qualified right of another causing damages; or some public right resulting in some substantial or particular damage to some person beyond that which is suffered by public generally and gives rise to an action for damages at the suit of the injured party[38].Negligence is defined in *Blyth v.Birningham Water Works Company*[39]as, "… omission to do something which a reasonable man guided upon those considerations which ordinarily regulate human affairs, would do, or doing something which prudent and reasonable man would not do".

In essence, actionable negligence consists in the neglect of the use of ordinary care or skill towards a person to whom the defendant owes the duty of observing ordinary care and skill, by which neglect the plaintiff has suffered injury to his person or property. The definition involves three constituents of negligence:

- A legal duty to exercise due care
- Breach of the said duty
- Consequential damage.

Cause of action for negligence arises only when damage occurs; for, damage is a necessary ingredient of this tort.[40]To put it simply, negligence is not 'neglect or carelessness'. But it is the failure to take such care as required in the particular context.[41]

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[36] Y.V.Rao, Law Relating to Medical Negligence 2-4 (1sted. 2006).
[37] Ian Storey, Duty of care and medical negligence, Oxford Journals Medicine & Health BJA: CEACCP124-12 (11(4) (2011).
[38] *Id* Rao
[39] Blyth supra note 34
[40] Ratanlal & Dhirajlal, Law of Torts 441-442 (24th ed. 2002).
[41] K.Mathiharan & Amrit k Patnaik ed.,Modi's Medical Jurisprudence and Toxicology 153-155 (23rd ed. 2005)

M A. JONES states, that:

> …as a tort negligence consists of a legal duty to take care and breach of that duty by the defendant causing damage to the plaintiff. Duty determines whether the type of loss suffered by the plaintiff in the particular way in which it occurred can ever be actionable. Breach of duty is concerned with the standard of care that ought to have been adopted in the circumstances, and whether the defendant's conduct fell below that standard, i.e., whether he was careless.[42]

SAHAI.J. expressed in *Jay Laxmi Salt Words (P) Ltd v State Of Gujarat:*[43]

> ..the axis around which the law of negligence revolves is duty, duty to take care, duty to take reasonable care. But concept of duty, its reasonableness and the standard of care required cannot be put in strait-jacket. It cannot be rigidly fixed. The right of yesterday is duty of today. The more advanced the society becomes the more sensitive it grows to violation of duties by private or even public functionaries. Law of torts and particularly the branch of negligence is consistently influenced and transformed by social, economic and political development

SALMOND did not accept the view that negligence was ever a purely objective fact involving characteristic or essential mental attitude at all. He has not even been of the opinion that negligence is a specific tort. According to him, it is merely a state of mind providing the essential condition of liability for recognized torts [44] .But the decision of House of Lords in *Donoghue v. Stevenson*[45] established that, negligence, where there is a duty to take care, is a specific tort in itself.

The fundamental idea behind liability for negligence is the duty of care[46].It was expressed in its modern form by majority of the House of Lords, in *Donoghue's* [47]case. In this case, a manufacturer of ginger beer sold beer in an opaque bottle to a retailer. The retailer sold it to a person who gave it to another. It was alleged that it contained decomposed part of a snail. The woman who consumed the beer alleged that she became seriously ill in consequence and sued the manufacturer for negligence. The doctrine of privity of contract prevented her

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[42] Rajkot Municipal Corporation v. Manjul Ben Jayantilal Nakum, (1997) 9 SCC 552
[43] 1994 SCC (4) 1, JT 1994 (3) 492
[44] R.F.V.HEUSTON, SALMOND ON LAW OF TORTS 196-198 (16TH ed.1973)
[45] 1932 AC 562
[46] G.H.FRIDMAN, MODERN TORT CASES 32-34 (1968)
[47] 1932 AC 562

bringing a claim founded upon breach of warranty in a contract of sale, but a majority of the House of Lords held that the manufacturer owed a duty to take care that the bottle did not contain noxious matter and that he would be liable in Tort, if that duty was broken.

Lord ATKIN said:

> The liability for negligence, whether you style it such or treat it as in other systems as a species of 'culpa' is no doubt based upon a general public sentiment of moral wrongdoing for which the offender must pay. But acts or omissions which any moral code would ensure cannot in a practical world be treated so as to give a right to any person injured by them to demand relief.

He has used neighbour test to decide the existence of a duty of care for personal injury and property damage:

> The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question, who is my 'neighbour?' receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who then in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.[48]

The House of Lords by Majority held that the respondent owed the appellant duty of care. The manufacturer is under a legal duty to the ultimate purchaser or consumer to take reasonable care that the articles are free from defect likely to cause injury to health. It must always be a question of circumstances whether the carelessness amounts to negligence, and whether the injury is too remote from the carelessness. The fact that there is contractual relationship between parties which may give rise to an action for breach of contract does not exclude the co-existence of a right of action founded on negligence between the same parties independently of contract[49].

Prior to *Donoghue's case*, a claimant would have to establish an existing duty relationship in order to be successful. The neighbor test taken in its widest sense

[48] 1932 AC 562
[49] RAO ,supra note 36

could be very broad allowing liability in a whole range of situations, however, subsequent cases narrowed down its application to only where a consumer was suing a manufacturer.

However, Lord WILBERFORCE sought to resurrect an all-embracing test for duty of care[50] in *Anns v. Merton London Borough Council*[51].

> The question has to be approached in two stages …first, one has to ask whether, as between the alleged doer and the person who has suffered damage there is sufficient relationship of proximity or neighborhood so that ,in the reasonable contemplation of the former, carelessness on his part may be likely to damage to the latter-in which case a *prima facie* duty of care arises.Secondly,if the question is answered affirmatively, it is necessary to consider whether there are any considerations, which ought to negative, or to reduce or to limit the scope of the duty or class of persons to whom it is owed or the damages to which the breach of it may give rise.

Foreseeability of the act is significant, as it is the determining factor not only in imposing duty to take care, but also in for limiting the liability of persons to whom the duty is owed. It was stated that, "The reasonable man is only bound to foresee the probable consequences of the act and not all the possible consequences, because in the simplest and apparently least harmful act there are always possibilities of damage, improbable though that damage may[52]."

2.4 PROFESSIONAL NEGLIGENCE

SCRUTTON L.J. has expressed in *Commissioners of Inland Revenue v. Maxse*[53] that:

> … 'profession', in the present use of language involves the idea of an occupation requiring either purely intellectual skill, or manual skill, controlled, as in painting, sculpture, or surgery, by the intellectual skill of the operator, as distinguished from an occupation which is substantially the production or sale or arrangement for the production or sale of commodities. The line of demarcation may vary from time to time. The word `profession' used to be confined to the three learned

[50] Case study, *Donoghue vs. Stevenson,Negliegence-duty of care*. (Last visited on 11/13/2015 at 9.46 a.m)http://www.e-lawresources.co.uk/Duty-of-care.php.
[51] 1977 (2) All ER 492 (HL)
[52] RAO,supra note 36
[53] 1919 1 K.B. 647

> professions, the Church, Medicine and Law. It has now, I think, a wider meaning.

In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task[54].

Occupations which are regarded as professions have four characteristics[55].They are the following.

- The nature of the work which is skilled and specialized and a substantial part is mental rather than manual;
- Commitment to moral principles which go beyond the general duty of honesty and a wider duty to community which may transcend the duty to a particular client or patient;
- Professional association which regulates admission and seeks to uphold the standards of the profession through professional codes on matters of conduct and ethics; and
- High status in the community.

In the matter of professional liability professions differ from other occupations for the reason that professions operate in spheres where success cannot be achieved in every case and very often success or failure depends upon factors beyond the professional man's control. In devising a rational approach to professional liability which must provide proper protection to the consumer while allowing for the factors mentioned above, the approach of the courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as

[54] Jacob Mathew v. State of Punjab, 2005 CTJ 1085
[55] Indian Medical Association v. V.P. Shantha & Ors, 1996 AIR 550

well as in contract to exercise reasonable care in giving advice or performing services[56]

The famous observation made by McNair J in *Bolam v.Friern Hospital Management Committee*[57]is defining negligence by professional generally:

> Where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Claphum omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have this skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

The Supreme Court of India in *Jacob Mathew vs. State of Punjab*[58] after an exhaustive survey on laws in this area and an in-depth analysis of both English and Indian decisions, observed that:

> A lawyer does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on. The only assurance which such a professional can give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practicing and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. … The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practices

In the same lines, Bingham L.J. stated "…. that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members of his profession in knowledge of new advances, discoveries and developments in his field…."[59]

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[56] *IMA* supra note 55
[57] (1957)1 WLR 582,(1957)2 All.ER 118
[58] *Jacob Mathew* supra note 54
[59] Eckersley v. Binnie, [1988] 18 Con. L.R I, 79,

2.5 LAW ON MEDICAL NEGLIGENCE

2.5.1 HISTORY

The oldest known source that mentions medical negligence is the Code of Hammurabi which was developed by Babylon's Kings, some twenty centuries before Christ. It fixed fee for treatment and penalty for improper treatment[60].

The ancient Mosaic Law perpetuated the concept of,'lex Talionis' or Law of Talion by demanding 'an eye for an eye' and 'a tooth for tooth'. Ancient Egyptian law provided for punishment of Medical wrong doer and similar provisions are there in Roman Civil Law. Medieval Law was also hard on errant 'barbers and surgeons'[61]

The earliest known treatise on Indian law '*Manusmriti*' states that all physicians who treat wrongly shall be liable to pay a fine .The first authoritative book on Indian medicine is *Agnivesa Charaka Samhita.*It was written somewhere in the 7th century BC and deals with elaborate code of practice of physicians with regard to their training,duties,privileges and their social status[62].In this earliest Indian medical literature, the word, '*Mithya*' is used to describe medical negligence.Mithya means false, illusive, incorrect, erroneous and improper.*Charaka Samhita* uses the word in the sense of wrong treatment. In *Sushruta Samhita*, the word '*mithyopachara*' is used in the sense of improper conduct and provides for punishment of such action.Koutilya's '*Arthashashtram*' also contains clear provisions for penalization of improper medical conduct. *'Yagnavalkya Smriti'* indicates 1000 *panas* as the highest penalty for medical negligence[63]

In all these civilizations medical negligence was treated as a crime. The objective of legal machinery was to protect and vindicate the interest of public by punishing the wrong doer. No amount of compensation used to be awarded

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[60] JUSTICE K KANNAN(ed.),MODI'S TEXT BOOK OF MEDICAL JURISPRUDENCE AND TOXICOLOGY103-138 (25th ed.2016)
[61] KANNAN supra note 60
[62] NANDITA ADHIKARI,LAW AND MEDICINE 1-5 (2007)
[63] KANNAN supra note 60

to the victims or their people. However as society progressed, the trend to consider negligence as a Tort (civil wrong) influenced judiciary and a practice of giving compensation to the victim has developed.[64]

Unlike the intentional Torts like, assault, battery and false imprisonment, Negligence which is an unintentional Tort, is relatively a modern legal development. In English Common law, the earliest recorded action against a medical man, brought before the King, was in 1374 .Though in that case the surgeon was held not liable, the court expressed that if negligence is proved, the court would provide for a remedy.[65]In 1395, William Leeche was found guilty for accepting fees without effecting cure.[66] In 1533 Holy Emperor Charles I decreed a significant change in the approach that medical malpractice must be judged by medical men.[67]

The Industrial Revolution of 18th century accelerated the growth of law of negligence as a separate Tort. And Law of Medical negligence also originated as an offshoot of law of negligence. In 1838, CJ Tyndall while deciding the standards for skill and care in medical treatment said, "…every person who enters a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill."[68]

2.5.2 INGREDIENTS OF MEDICAL NEGLIGENCE

The public profession of an art is a representation and undertaking to the entire world that the professor possesses the requisite ability and skill[69]. The rule that a man is expected to exercise only the degree of care which an ordinary prudent man would exercise is subject to this important exception. A professional who undertakes something requiring special knowledge or skill will be considered

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[64] KANNAN supra note 60 at 104-106
[65] MATHIHARAN & PATNAIK supra note 41 ,quoting *Swing The Doctors-An Inexorable Spiral*,editorial,The Medico-Legal Journal 63-67 at 65Vol 55Part 2(1987)
[66] KANNAN supra note 60 at 104-106
[67] KANNAN supra note 60 at 104-106
[68] Lauphire v.Phipos (1838),8C & P,P475; 34 Digest 548, (1835-42) All ER Rep 421
[69] Harmer v. Cornelius (1858) 5 CB (NS) 236 ,quoted by R.M JHALA & V.B.RAJU ,MEDICAL JURISPRUDENCE 53-57 (4th ed.1982)

negligent, if by reason of his not possessing the required knowledge, he bungles although he does his best[70].Medical Negligence is proved, if,

- the doctor had a duty of care to the patient
- he has committed a 'breach' of that duty and,
- the patient suffered a damage as a result.

Duty of care

A doctor owes a duty of care to his patients, once the doctor-patient relationship is established. A doctor has a legal obligation to patients to adhere to a standard of reasonable care[71] .

According to *Halsbury's Laws of England*:

> A person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, whether he is a registered medical practitioner or not, who is consulted by a patient, owes him certain duties, namely, a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give; and a duty of care in his administration of that treatment. A breach of any of these duties will support an action for negligence by the patient.[72]

The extent of civil liability of medical men towards their patients is well established by Lord HEWART in one of the earliest cases *R v. Bateman*[73].

> If a person holds himself out as possessing special skill and knowledge and is consulted as possessing that special skill and knowledge…he owes a duty to the patient to use diligence ,care, knowledge, skill and caution in administering the treatment….The law requires a fair and reasonable standard of care and competence. The standard must be reached in all the matters above mentioned.

The duty to exercise skill and care exists when a doctor patient relationship is established. Even in an acute emergency a doctor forms a full doctor-patient relationship as soon as he approaches a patient with the object of treating

[70] Heaven v. Pender (1883) 1 QBD 503
[71] Dean et al., *Duty of care or a matter of conduct.Can a doctor refuse a person in need of urgent medical attention?*.Australian Family physician 746-748 Volume 42, No.10, October (2013)
[72] Halsbury's Laws of England 17-18, 4th ed., Vol.26
[73] (1925) 24 LJ KB 791

him.Thus a doctor who deals with a patient with the intent of acting as a healer establishes a doctor-patient relationship immediately, and from that moment on, he has a legal obligation to exercise a duty of skill and care. Any breach of duty is ground for a negligent action[74]

Breach of Duty

Lord President CLYDE stated "The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with reasonable care"[75]

Lord HEWWART C.J, further noted that, "it is no doubt conceivable that a qualified man may be held liable for recklessly undertaking a case, which he knew, or should have known, to be beyond his powers, or making his patient subject of reckless experiment.[76]"

The locus classicus test of the standard of care required of a doctor or any other person professing some skill or competence is the direction to the jury given by MCNAIR J. in *Bolam v. Friern Hospital Management Committee* :[77]

> I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . . Putting it the other way 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.

Facts of the case

The plaintiff, a voluntary patient in the defendant's mental hospital sustained fractures in the course of electro convulsive therapy. There were two bodies of opinion in the profession about the mode of the treatment

- Relaxant drugs or manual control to be used as general practice.

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[74] P.C DIKSHIT, HWV. COX MEDICAL JURISPRUDENCE AND TOXICOLOGY, (7th ed.2002)
[75] Hunter v.Hanley (1957) SLT 213
[76] *Bateman* supra note 73
[77] *Bolam* supra note 57

- The use of such drugs should be confined to cases only there were particular reasons for their use.

The doctor was held not negligent for failing to administer a relaxant drug prior to the treatment and in failing to provide some form of manual restraint during the passing of electric current through the brain of the patient.MC.NAIR.J [78] in his classic address to the jury stated the law as:

> ….where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Claphum omnibus,beause he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have this skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

Approving this Test in *White House v.Jordan*, [79]the House of Lords held that, "error of judgment could be negligence if it is an error which would not have been made by a reasonably competent professional man acting with ordinary care". Lord FRASER made the candid statement:

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

J STREATFIELD expressed in *Patch v. Board Governors, United Bristol Hospital*[80]*:*

> It is stated that the liability of doctors is not unlimited. The standard of care required of them is not that standard required by exceptional practitioners. Surgeons, doctors and nurses are not insurers. They are not guaranteeing of absolute safety. They are not liable in law not merely because a thing goes wrong…The law requires them to exercise professionally that skill and knowledge which belongs to the ordinary practitioner

[78] *Bolam* supra note 57
[79] (1981) 1 All ER 267 (HI)
[80] MATHIHARAN & PATNAIK supra note 41

Lord Denning in *Rao and Woolley v. Ministry of Health*[81]held that:

> …we should be doing a disservice to the community at large if we were to impose liability for everything that happens to go wrong….We must insist on due care of the patient at every point but we must not condemn as negligence that which is only a misadventure." In this same decision it was also observed that, "It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind but these benefits are attended by unavoidable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way.[82]

In *Eckersley v. Binnie*, Bingham, L.J.[83] summarized *Bolam* test in the following words:

> From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members of his profession in knowledge of new advances, discoveries and developments in his field. He should have such awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet.

In *Maynard v. West Midlands Regional Health Authority* [84]the words of Lord President CLYDE in *Hunter v. Hanley*[85] were quoted:

> In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men...The true test for establishing negligence in diagnosis or treatment on the part

[81] [1954]2 All ER131,2 QB 66 CA
[82] Kusum Sharma v. Batra Hospital &Med.Research centre AIR 2010 SC 1050
[83] *Id*
[84] (1984] 1 W.L.R. 634
[85] 1955 SLT 213

> of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care....[86]

Similar view was reflected in *Indian Medical Association* case as well. "In devising a rational approach to professional liability which must provide proper protection to the consumer while allowing for the factors mentioned above, the approach of the Courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties."[87]

> You should only find him guilty of negligence when he falls short of the standard of a reasonably skillful medical man, in short, when he deserving of censure – for negligence in a medical man is deserving of censure.…but so far as the law is concerned, it does not condemn the doctor when he only does …which may a wise and good doctor so placed would do... only …when he falls short of the accepted standards of a great profession;…when he is deserving of censure.

SALMOND observes:

> It is expected of such a professional man that he should show a fair, reasonable and competent degree of skill; it is not required that he should use the highest degree of skill, for there may be persons who have higher education and greater advantages than he has, nor will he be held to have guaranteed a cure. Although the standard is a high one, a medical practitioner should not be found negligent simply because one of the risks inherent in an operation of that kind occurs, or because in a matter of opinion he made an error of judgment, or because he has failed to warn the patient of every risk involved in a proposed course of treatment.[88]

In *Joyse v. Merton Sutton and Wands Worth Health Authority*,[89] a profound change in the attitude was visible when the court held that the "doctor would be guilty of negligence even if his acts or omissions were in accordance with the accepted clinical practice, … the court is duty bound to see … that a general practice stood up to analysis and was not unreasonable in the light of … medical knowledge of the time".

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[86] Kusum Sharma v. Batra Hospital &Med.Research centre AIR 2010 SC 1050
[87] *IMA* supra note 55
[88] R.F.V.Heuston supra note 44
[89] (1996)7 Mad LR 1

In *Hucks v. Cole,*[90] a doctor failed to treat with penicillin a patient who was suffering from septic places on her skin though he knew them to contain organisms capable of leading to puerperal fever. A number of distinguished doctors gave evidence that they would not, in the circumstances, have treated with penicillin. The Court of Appeal found the defendant to have been negligent. SACHS L.J. said,

> When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risk, the court must anxiously examine that lacuna–particularly if the risk can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence. In such a case the practice will no doubt thereafter be altered to the benefit of patients. On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf; but it is not, as Mr. Webster readily conceded, conclusive. The court must be vigilant to see whether the reasons given for putting a patient at risk are valid in the light of any well-known advance in medical knowledge, or whether they stem from a residual adherence to out-of-date ideas.

In down *Bolitho v. City and Hackney Health Authority* [91] the House of Lords modified the principle laid in Bolam's case.It was observed that:

> … in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence …it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

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[90] [1993] 4 Med. L.R. 393
[91] (1997) 4 All ER 771

Indian law

During British rule, English common law was introduced in the administration of justice in India. Prior to the introduction of Constitution of India in 1950, a very large number of English legal principles were followed and applied by the Indian Courts[92].

The law on medical negligence has evolved in India through a series of judgments over a period of time. Currently the law covers practically all aspects of this complex profession and its practice in this country. It takes cognisance not only of the development of the corresponding jurisprudence in the UK, USA and other developed countries but also of the delicate relationship between the physician and the patient, the ground realities of the available medical services and medical infrastructure as well as the socio-economic conditions in India.[93]

In *Sabhapati v. Huntley,*[94]it was held that:

> To render professional man liable, even civilly, for negligence or want of due care or skill, it is not enough that there has been a less degree of skill than some other medical men might have shown, or a less degree of care even he himself might have bestowed; nor is it enough that he himself acknowledges some degree of want of care; that must have been a want of competent and ordinary care and skill to such a degree as to have led a bad result.

J TENDULKAR observed in *Amelia Falunders v.Clement Pereira*[95], " Actions for negligence in India are to be determined according to the principles of English common law and those principles have been set out in an action for negligence against medical men".

EARLE, CJ[96]said:

> A physician in the normal course is not responsible to his patient for the evil consequences of his prescriptions or surgical operations as they are entirely out of his will and ability to control. However he will be held

[92] MATHIHARAN & PATNAIK supra note 41
[93] K. A. Bhandula v Indraprastha Apollo Hospital & Others III (2009) CPJ 164 (NC)
[94] AIR 1935 Lah 247,quoted by R.M JHALA & V.B.RAJU ,MEDICAL JURISPRUDENCE 53-57 (4th ed.1982)
[95] Bombay High Court, OOCJ Suit No.808 of 1943 (Unreported),quoted by MATHIHARAN & PATNAIK supra note 9 at 155
[96] Rich v.Pierpoint (1862) 3F & F 35

> liable if those consequences arise out of his ignorance or want of skill, as far as he is the willful cause of such ignorance or want of skill. It can be either, he should have known better or not, knowing better, he should not have undertaken the case for which he knew he was not qualified.

The Supreme Court in *Laxman Balkrishna Joshi v.Trimbak Bapu Godbole* [97] quoted *Halsbury's Law of England*:

> The duties which a doctor owes to his patient are clear. A person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, when consulted by patient, owes him certain duties, namely, a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give, a duty of care in his administration of treatment. A breach of these duties gives a right of action for negligence to the patient.

In *Indian Medical Association v.V.P.Shanta*,[98] the Supreme Court mentioned:

> …the approach of the courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise a reasonable care in discharge of their duties .In general a professional man owes to his clients a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services.

The statement made by MCNAIR J. in *Bolam* case[99] 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 the courts in India and applied to as touch stone to test the pleas of medical negligence.[100]

In *Suresh Gupta's* case,[101]Supreme Court of India held that the legal position is quite clear and well settled that whenever a patient died due to medical negligence, the doctor is primarily liable under civil law.Only when the negligence is so gross and his act was as reckless as to endanger the life of the patient, he will be charged under section 304A of Indian Penal Code.[102]

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[97] AIR 1969 SC 128
[98] AIR 1996 SC 550
[99] (1957) 1 WLR 582
[100] Poonam Verma v. Aswin Patel and others., 1996 CTJ 65 (SC) (CP), (1996) 4 SCC 332
[101] Suresh Gupta v. Government of N.C.T. of Delhi AIR 2004 SC 4091
[102] Anurag K. Agarwal, *Medical Negligence: Law and Interpretation* (Working paper,23-03-2011). https://ideas.repec.org/p/iim/iimawp/10000.html. Last visited on 01-10-2016 at 20.56

A mere deviation from normal professional practice is not necessarily evidence of negligence, so also an error of judgment. Higher the acuteness in emergency and higher the complication, more are the chances of error of judgment. A doctor has to –at times- adopt a procedure which involves higher element of risk, but which to the best of his knowledge, the right one So long as it can be found that the procedure adopted was one which was acceptable to medical science as on that date, it cannot be held to be negligence.[103]

Test of Reasonableness

As far as medical men are concerned there is always a possibility of a claim for medical negligence by dissatisfied patient. A doctor has a duty to exercise reasonable care, breach of which makes him liable for damages. If he acted in accordance with well established practice he would not be liable[104]

In *A.S Mittal v. State of U.P*,[105]The Supreme Court reiterated its own decision in Dr.Laxman Balkrishna Joshi:[106] It was observed that, "Mistakes will occur on occasions despite the exercise of reasonable skill and care; the law recognizes the dangers which are inherent in surgical operations". In that case,though the Court refrained from deciding, whether the doctors were negligent ,the opinion was that If a medical practitioner committed a mistake which no reasonably competent and a careful practitioner would have committed is a negligent one. The Court also took note that the law recognizes the dangers which are inherent in surgical operations and that mistakes will occur, on occasions, despite the exercise of reasonable skill and care.

In Tort, it is enough for the defendant to show that the standard of care and the 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. Firstly, the standard of care, when assessing the practice as adopted, is judged in the

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[103] *Jacob Mathew* supra note13
[104] Indira Kartha v.Mathew Samuel Kalaickal and Another,2002 NCJ 377 (NC)
[105] 1989 (3) SCC 223
[106] AIR 1969 SC 128

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[107]. `

In *Malhotra v.A.Kriplani,*[108]it was held that:

> Negligence in the context of the medical profession necessarily calls for a treatment with a difference. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed.

In *Jagdish Ram v. State of Himachal Pradesh*[109], the Himachal Pradesh High Court, following *Jacob Mathew* decision, observed that:

> It is also unjustified to impose on those engaged in medical treatment an undue degree of additional stress and anxiety in the conduct of their profession. Equally, it would be wrong to impose such stress and anxiety on any other person performing a demanding function in society. While expectations from the professionals must be realistic and the expected standards attainable, this implies recognition of the nature of ordinary human error and human limitations in the performance of complex tasks.

The Supreme Court in *Achut Rao Haribhau Khodwa and others v. State of Maharashtra* [110]held:

> The skill of medical practitioners differs from doctor to doctor. The very nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession, and the Court

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[107] *Jacob Mathew* supra note 13
[108] (2009) 4 SCC 705
[109] 2008 ACJ 433
[110] AIR 1996 SC 2377, 1996 (2) SCC 634

> finds that he has attended on the patient with due care skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence.

In *Vinitha Ashok v. Laxmi Hospitals and Another*[111]the Supreme Court of India had an occasion to refer to the decision in *Bolitho*.After examining the development in English Law and referring its earlier decisions, *Laxman Balakrishna,*[112]*IMA*[113] *and Achut Rao,*[114]relying upon *Bolitho* accepted the test of reasonableness .The Court observed :

> Thus in large majority of cases, it has been demonstrated that a doctor will be liable for negligence in respect of diagnosis and treatment in spite of a body of professional opinion approving his conduct where it has not been established to the courts satisfaction that such opinion relied on is reasonable or responsible. If it can be demonstrated that the professional opinion is not capable of withstanding the logical analysis, the court would be entitled to hold that the body of opinion is not reasonable or responsible.

Chances of error

Medicine is an inexact science it is unlikely that a responsible doctor would intend to give an assurance to achieve a particular result[115]. It is not generally acceptable to castigate a mere error of judgment. Errors in treatment can take a multitude of forms and for variety of reasons.[116]Even after adopting all medical procedures as prescribed, a qualified doctor may commit an error. The Supreme Court has held, in several decisions, that a doctor is not liable for negligence or medical deficiency if some wrong is caused in her/ his treatment or in her/ his diagnosis if she/ he has acted in accordance with the practice accepted as proper by a reasonable body of medical professionals skilled in that particular art, though the result may be wrong. In various kinds of medical and surgical treatment, the likelihood of an accident leading to death cannot be ruled out. It is implied that a patient willingly takes such a risk as part of the doctor-patient

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[111] AIR 2001 SC 3914
[112] AIR 1969 SC 128
[113] 1996 AIR 550
[114] AIR 1996 SC 2377, 1996 (2) SCC 634
[115] C.S. Subramanian v.Kumarasamy (1994) 1 MLJ 438
[116] *Id*

relationship and the attendant mutual trust.[117]In *State of Haryana and others v. Santra,*[118]the Apex court observed that, there is an "implied undertaking" by every person who enters in to medical profession that he would use a fair, reasonable and competent degree of skill. The Court has set the standard of care in explicit words in *Nizam's Institute v. Prasanth .Dhananka,*[119] " To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence." An error of judgment or an accident, is not accepted as a proof of professional negligence.

Negligence per se

In *Poonam Verma v. Ashwin Patel,*[120] the Supreme Court observed that negligence has many manifestations. " It may be active negligence, collateral negligence, comparative negligence, concurrent negligence, continued negligence, criminal negligence, gross negligence, hazardous negligence, active and passive negligence, willful or reckless negligence or Negligence per se." This case is a land mark in Indian legal history for the clarification given by the Court that " a homeopath prescribing Allopathic medicine is *negligence per se* and makes the person liable even without an evidence of direct nexus between the act and injury."In a similar verdict,[121] a doctor who is authorized to practice Ayurveda system of medicine was held to be negligent for prescribing allopathic medicine.

2.6 BURDEN OF PROOF

The burden of proof of negligence, carelessness, or insufficiency generally lies with the complainant. The law requires a higher standard of evidence than otherwise, to support an allegation of negligence against a doctor. In cases of medical negligence the patient must establish his claim against the doctor. The

[117] K K S R Murthy, *Medical negligence and the law*, Indian Journal of Medical Ethics, Vol 4, No 3 (2007) . http://www.ijme.in/index.php/ijme/article/view/592/1506
[118] (2000) 5 SCC 182
[119] (2009) 6 SCC 1.
[120] (1996) 4 SCC 332
[121] S.K.Sharma v.L.C.Sharma 2004 (3) CPJ 612 (Delhi)

complainant has to prove the presence of duty of care, breach of care and the consequential damages suffered by him. Lord DENNING in the case of *Hatcher v. Black*[122], expressed,

> …the jury must not find a doctor negligent simply because one of the risks inherent in an operation actually took place or because in a matter of opinion he made an error of negligent. They should only find him guilty when he had fallen short of the standard of medical care.

2.6.1 *Res Ipsa Loquitur*

In all civil cases the onus of proof is on the complainant. That means the complainant has to convince the court that his version of the events is more than 50% likely to correct, which becomes difficult at times[123].The principle of *res ipsa loquitur* is reducing this burden.

The Latin maxim *res ipsa loquitur* means that the thing speaks for itself. Application of this maxim places on the defendant the onus of disproving this presumption of negligence. It reverses the burden of Prof. STREET [124]states:

> *Res ipsa loquitur* is not principle of substantive law; it is a rule of evidence, an expression which is convenient to apply to those circumstances in which a plaintiff in negligence discharges his task of establishing want of care on the part of the defendant without having to prove any specific negligent act or omission by the defendant.

The following criteria is considered essential to apply this doctrine.

- The Couse of the injury must be unknown or unascertainable
- Common knowledge or expert evidence suggests that the injury, by its very nature, cannot occur without negligence
- The doctor(defendant) must have been in control of the situation[125]

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[122] Paul Nisselle, *Is Self-disclosure a Boundary Violation*? J Gen Intern Med (v.19(9); 2004). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1492525/disclosuhttp://www.ncbi.nlm.nih.gov/pmc/articles/PMC1492525/.Last visited on 10-107-2016 at 13.09 .

[123] JAGDISH SINGH & VISHWA BHUSHAN,MEDICAL NEGLIGENCE AND COMPENSATION 115-117(2nd ed. 1999)

[124] HARRY STREET,THE LAW OF TORTS 130-135 (5th ed. 1972)

[125] Scott v. London and St. Katherine's Docks,(1865)2 H&C 596 as quoted by JAGDISH SINGH & VISHWA BHUSHAN,MEDICAL NEGLIGENCE AND COMPENSATION 115-117(2nd ed. 1999)

In *Spring Meadows Hospital and another v. Harjol Ahlu Walia*[126] The Supreme Court observed, "…use of wrong drug or wrong gas during the course of anaesthetic will frequently lead to the imposition of liability and in some situations even the principle of *res ipsa loquitur* can be applied. Gross medical mistake will always result in a finding of negligence"

Res ipsa loquitur is a rule of evidence which in reality belongs to the law of torts. Inference as to negligence may be drawn from proved circumstances by applying the rule if the cause of the accident is unknown and no reasonable explanation as to the cause is coming forth from the defendant.[127]

According to P.R. AIYAR's Law Lexicon,[128]"…simply because a patient has not favourably responded to a treatment given by a doctor or a surgery has failed, the doctor cannot be held liable for medical negligence by applying the doctrine of '*res ipsa loquitur'*[129]

In *Achutrao Haribhau Khodwa v. State of Maharashtra,* [130] the deceased Chandrikabai was admitted in the Civil Hospital, Aurangabad for delivery. This maternity hospital is attached to the Medical College at Aurangabad .She had got herself admitted to this hospital with a view to undergo a sterilization operation after the delivery. Thereafter Chandrikabai developed high fever and also had acute pain which was abnormal after such a simple operation. Her condition deteriorated further and on 15th July, 1963 appellant approached Medical Officer and one Dr. Divan, who was a well-known surgeon and was attached to the hospital, but was not directly connected with the Gynaecology department. At the insistence of patients relative, Dr. Divan examined Chandrikabai, and seeing her condition, he has suggested that the sterilization operation which had been performed should be re-opened. This suggestion was not acted upon and the condition of the patient became very serious. Later, Dr. Divan, on being called once again, re-opened the wound of the earlier operation

[126] AIR 1998 SC 1801, 1998(4) SCC 39
[127] *Jacob Mathew* supra note 13
[128] P.RAMANATHA AIYAR supra note 31 at 1113-1114
[129] Martin F D' souza v. Mohd. Isfaq, (2009) 3 SCC 1,17, para 40
[130] (1996) 2 SCC 634

in order to ascertain the true cause of the seriousness of the ailment and to find out the cause of the worsening condition of the patient. As a result of the second operation, It was found that a mop (towel) had been left inside the body of the patient when sterilization operation was performed on her. It was further found that there was collection of pus and the same was drained out. Thereafter, the abdomen was closed and the second operation completed. Even, thereafter the condition of patient did not improve and ultimately she expired in a week's time.

Holding the doctors liable, the Court expressed that:

> In the present case the facts speak for themselves. Negligence is writ large. The facts as found by both the courts, in a nutshell, are that Chandrikabai was admitted to the government hospital where she delivered a child on 10th July, 1963. She had a sterilization operation on 13th July, 1963. This operation is not known to be serious in nature and in fact was performed under local anesthesia. Complications arose thereafter which resulted in a second operation being performed on her on 19th July, 1963. She did not survive for long and died on 24th July, 1963. Both Dr. Divan and Dr. Purandare have stated that the cause of death was peritonitis. In a case like this the doctrine of res ipso loquitur clearly applies.

In .*N.K.Gourikutty v.M.K.Madhavan* [131], the Kerala High Court held that the anesthetist and the other staff liable for negligence applying the principle of *res ipsa loquitur.*

In another case, the doctor who performed the operation did not produce operation notes as regards number of pads issued and instruments used at the time of the operation. The Court held that, principle of *res ipsa loquitur* is applicable in this case[132].

2.6.2 CAUSATION

Causation is more significant in negligence cases, though it is generally applicable to all Tort cases. The law of causation determines not only to what extent damages are recoverable, but also whether the action succeeds at all. In case of a negligence suit, the plaintiff must put in direct or circumstantial

[131] AIR2001 Ker 398(DB)
[132] Aparna Datta v. Apollo Hospital,2002 ACJ 954 (Madras)

evidence which will show how the accident that there is an injury and that was resulted from defendants negligent conduct.[133]Every occurrence is the result of many conditions which are jointly sufficient to produce it.If the event could not have occurred unless that condition existed, that is a cause for the event[134]. STREET [135]observes :

> …there is no precise legal rule, but common sense and law unite in looking for the abnormal or the deliberate human act, and regarding that as "the cause". In medical negligence cases, it is necessary to prove that, professional's breach of the standard of care caused or contributed to causing some harm to the patient.

The 'but for' test

If the damage to the plaintiff would not have happened 'but for' the defendants negligence, then the negligence is a cause of the damage. If the loss would have caused in any event, then conduct is not cause. In *Barnett v. Chelsea an Kensington Hospital Management Committee,* [136] patients attended hospital complaining vomiting. The causality officer, without check-up, advised them to go home and see their own doctors. Within hours, one of them died of arsenic poisoning. It was held that the causality officer was negligent. However, it cannot be said that but for the doctors negligence the patient would have lived, because the medical evidence indicated that even if the patient had received proper treatment, it would not have been possible to diagnose the condition and administer antidote in time to save him. Thus the negligence did not cause the death.

This type of causation problem arises in medical negligence, because, the plaintiff raises the contention that, but for the doctors negligence, he would have opted for an alternate course of treatment[137].In *Bolitho v. City and Hackney Health Authority*[138], a two year old boy suffered brain damage as a result of cardiac arrest caused by an obstruction of bronchial air passage. The claimant

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[133] STREET supra note 124
[134] *Id*
[135] *Id*
[136] [1968] 1 All E.R.1068
[137] MICHAEL A JONES, MEDICAL NEGLIGENCE 444-445 (4th ed. 2008)
[138] [1993]4 Med.L.R.381

was in hospital and the doctor did not attend the calls by nursing staff for assistance. It was common ground that had the claimant been seen by a doctor and intubated, the tragedy could have been avoided. There were two schools of thought, however, whether in the claimant's circumstances it was appropriate to intubate. The doctor who failed to attend maintained the stand that, even if she attended the patient, she would not have intubated and therefore the cardiac arrest and the resultant bran damage would have happened anyway.

On an appeal to House of Lords, it was contended on behalf of the claimant that, the Bolam test had no relevance in determining question of causation. Lord BROWNE-WILKINSON agreed that, as a general proposition that was correct. In all cases the primary question is one. Did the negligence cause the injury? But in cases where the negligence arises out of an omission to do an act which ought to have been done, the factual enquiry is hypothetical. The question is what would have happened? The Bolam test was not, and could not, be relevant to that question. The defendant doctor says that she would not have intubated, and therefore the claimant in any way would have suffered the injury. She could not escape liability by proving that she would have failed to act as any reasonably competent doctor would have acted in similar circumstances.[139]

'But for' test operates as an initial filter to excludes events which did not affect the outcome. It cannot however solve all the problems of factual causation[140].The complaint in a medical negligence case is always not that the doctor inflicted injury .But that as a result of the defendants negligence, his medical condition did not improve or was allowed to deteriorate [141] .In determining the liability in cases where there is factual uncertainty was evolved in *Hotson v. East Berkshire Area Health Authority*[142].The patient claimed that doctor's negligence has deprived him of a 25% chance of making a good recovery, whereas the defendant argued that the plaintiff failed to prove, on the balance of probabilities, that the negligence caused the disability. Though the

[139] JONES supra note 137
[140] JONES supra note 137
[141] *Id*
[142] [1987]A.C. 750, C.A and H.L.

trial judge and Court of appeal favoured the plaintiff's contention, the House of Lords reversed the order stating that there was high probability, put at 75% ,that even with correct diagnosis and treatment, the patients disability would have occurred. The Court held that this is not a 'lost chance'. It was an all or nothing case. The valuation of a 'lost chance' will arise only once the causation is established[143].

In *Allied Maples Group Ltd. v. Simmons & Simmons*[144] ,the Court of Appeal suggested the categorization based on whether the negligence consists in some positive act or omission. In the case of a positive act, of misfeasance, the question of causation is a historical fact, which once established on the balance of probability is taken as true. Where the defendants negligence consist of an omission, e.g. to give proper treatment, proper advice, causation depends not on the historical fact but on the answer to the hypothetical question, what would the claimant have done, if the treatment had been provided or the advice given? This will be a matter of inference to be decided from circumstances.Morover although the question is hypothetical, the claimant has to prove the balance of probability that he would have taken action to obtain benefit or avoid risk. Similarly with positive act, he has to establish that, there is no discount of damages simply because the balance is only just tipped in his favour[145].In *Smith v. National Health Service Litigation Authority*[146]the defendant argued that Allied Maples did not apply to actions for medical negligence. Rejecting the contention, Andrew SMITH J. said that Allied Maples laid down the general principles and there was no reason to adopt a different approach[147].

In *Gregg v. Scott*[148], the doctor negligently failed to refer a patient having lipoma-a benign collection of fatty tissue- for a specialist investigation. As a result of this, the patient's treatment was delayed and this significantly reduced his chances of survival. The trial judge and the Court of appeal dismissed the

[143] JONES supra note 137
[144] [1995]4 All ER.907
[145] JONES supra note 137
[146] [2001] Lioyd's Rep.Med.90
[147] JONES supra note 137
[148] [2005] 2 A.C. 176

claim applying *Hutson*.House of Lords too by a majority of 3:2 rejected the claim. Despite the majority decision, it remains arguable that in some circumstances a missed diagnosis could give rise to a claim based on a lost chance of a better medical outcome[149].

Where there are two independent events, each of which were sufficient to have caused the damage sustained by the claimant, the determination of casual responsibility depends on the nature of events and the order in which they occurred. In *Baker v.Willoubhby*[150],the claimant suffered an injury to his left leg due to defendants negligence. He was subsequently shot in the same leg during an armed robbery resulting in the amputation of the leg. The defendant claimed that the supervening amputation has submerged the original injury and he has to give compensation only till the date of the shooting. The House of Lords held that the defendant remained responsible for the initial disability even after the amputation[151]. *Wilsher v Essex Area Health Authority* [152], a junior doctor administered excessive oxygen to a premature child during the post-natal care; this lead to blindness. The medical experts provided evidence that there are five further causes that might have led to blindness. The Lords, therefore, found that it was impossible to say that it had caused, or materially contributed, to the injury and the claim was dismissed. In *Whitehouse case* a mother in a high-risk pregnancy, who had been in labour for 22 hours was assisted by forceps. The child suffered severe brain damage. The surgeon was not found negligent as the standard of care did not fall below that of a reasonable doctor in the circumstances [153]

2.6.3 REMOTENESS OF DAMAGE

Remoteness of damage is a confusing subject, not because it is difficult in itself, but because, like an archeological site, it has been overlaid with successive theories which are inconsistent with one another[154].In remoteness of damage, it

[149] JONES supra note 137
[150] [1970]A.C 467
[151] JONES supra note 137
[152] 1988. A.C 1074
[153] Whitehouse v Jordan. 1981. 1 All ER 267.*Id*
[154] JOHN MUNKMAN,DAMGES FOR PERSONAL INJURIES AND DEATH 19-24(3rd.Ed. 1966)

can be argued that either the injury itself is too remote from the negligent act or some of the losses are, to be consequential to the injury. In *S.S.S.Abbey's* case,[155]two ships were cast adrift from their moorings in harbor. Due to the action of the defendant ship, it was alleged that they came in a position of danger. Since it was found that, still the ships were able to navigate as free agents, defendant was not held liable for the accident.

In personal injury cases, such questions can be raised when the injury is caused by a mistake which is made during a medical treatment.[156] Generally the defendant is liable for the direct consequences his negligent medical service. If the plaintiff has acted in a reasonable manner in the difficult situation created by the defendant, consequential losses of such intervention are considered to be direct or not remote.[157] If the plaintiff has incurred expenses by following mistaken medical advice, it is forseeable.Lord PATRICK [158]said:

> It is a reasonable and probable consequence of a wrongdoer's breach of duty that a person hurt will incur expense in following the treatment prescribed by reputable experts employed by him to cure him. Each case must be decided on its own merits."[159] However there can be situations where further damage is resulted from the negligence of the doctor. Even suicide can be a result of a disturbed mental state following a wrong treatment[160]

2.7 VICARIOUS LIABILITY

In general a person is responsible only for his own acts. But there are exceptional cases in which the law imposes on him liability for the acts of others, however blameless he may be. Vicarious liability means liability is incurred for, or instead of, another. The liability arising out of relationship of master and servant is one of the kinds of vicarious liability[161]

> Vicarious liability means that one person takes or supplies the place of another so far as liability is concerned. This phrase means the liability of a person for the tort of another in which he had no part. A master is

[155] S.S.Singleton Abbey v. S.S.Paludina [1927] A.C.16
[156] Rubens v. Walker [1946] SC 215
[157] MUNKMAN supra note 154
[158] Rubens v. Walker [1946] S.C 215
[159] As quoted by MUNKMAN supra note 154
[160] MUNKMAN supra note 154
[161] RAO,supra note at.83-84

> jointly and severally liable for any tort committed by his servant which acting in the course of his employment.[162]

Quid facit per alium facit per se,which means a person who does a thing through another does it himself and *respondeat superior*.i.e,let, let the superior be responsible are the two principles which governs the concept of Vicarious liability. Anyone who is authorizing other person to do an act on behalf of him also allows the other one to have the freedom to decide the method of action Therefore, in the course of action, if he commits any wrong, the master is answerable for such wrong. Such liability will arise only when, what is done is not an independent action of the servant. The principle demands that it was done in the course of employment.Morover it must be a justifiable method of achieving the purpose.[163]This doctrine is not developed out of some identifiable logic,but it is a doctrine of convenience .Lord PEARCE in *Imperial Chemical Industries Ltd. v. Shatwoll*[164], mentioned that,"It grown from any very clear, logical or legal principle but from social convenience and rough justice."[165]

A master becomes liable for the acts done by the servant in the course of his employment. The wrong can be natural consequence of something done by the servant with ordinary care in execution with master's specific order. The wrong may be due to servant's want of care, or negligence in carrying out the work or business in which he is employed.The servants' wrong may be originated from an excess of lawful authority or a mistake of understanding it. But it must be shown that the servant's intention was to do something which he was originally, authorized to do. And also ,he has done it in a proper manner which under that particular circumstance, would have been lawful.[166]

The wrong may be intentional wrong, done on behalf of master in order to serve his purpose.[167] Vicarious liability is the responsibility of A for the wrong act of B done againstC. When A himself had no part in B's conduct. In the literal sense, the doctrine of respondent superior means "let the master answer" and it

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[162] State of Rajasthan v. Shekhu . 2006 ACJ 1644
[163] RAO,supra note 36 at. 83-84
[164] 1965 AC 656,
[165] supra note 162
[166] RAO,supra note 36 at. 83-84
[167] *Id*

operates to render the master liable for the wrongs of his servant and the principal liable for the wrongs of his agent committed while furthering the master's or principal's business.[168]

In the case of *Collins v. Hertfordshire County Council* ,[169] while undergoing an operation, a patient in a county council hospital was killed by an injection of cocaine which was given by the operating surgeon in the mistaken belief that it was procaine. The operating surgeon had ordered procaine on the telephone, but the resident house surgeon had mis-heard "procaine" as "cocaine", and had told the pharmacist to dispense a mixture which was, in fact, lethal. The pharmacist dispensed the mixture without making further inquiry and without requiring the written instruction of a qualified person, and the operating surgeon had given the injection without checking that it was what he had ordered. The operating surgeon, the house surgeon, and the pharmacist were all three in the full-time or part-time employment of the council. Suit was filed by the patient's widow against the county council and the operating surgeon alleging that the death was the result of (a) the council's negligence in the conduct of their hospital, and (b) the operating surgeon's failure to exercise reasonable care. It was held as follows:

> The county council, in managing the hospital, was permitting a dangerous and negligent system to be in operation, and the operating surgeon and the house surgeon had failed to exercise reasonable skill and care. The council was able to control the manner in which the resident medical officer performed her work and, therefore, the acts of the house surgeon done in the course of her employment were acts for which the council was responsible, although the operating surgeon was a part-time employee on the staff of the council, the council could not control how he was to perform his duties and was not responsible for his want of care.

However, subsequently, this distinction was rejected in *Cassidy v. Ministry of Health* [170]. Lord DENNING observed that a hospital authority is liable for the

[168] Arthur F. Southwick, *Vicarious Liability of Hospitals*, 44 Marq. L. Rev. 153 (1960).
[169] [1947]1All E.R. 633.Quoted in Savita Garg v. National Heart Institute, (2004) 8 SCC 56,

[170] [1951] 2 K.B. 343

negligence of doctors and surgeons employed by the authority under a contract for service arising in the course of the performance of their professional duties.

> The hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors but also for the anesthetists and surgeon. It does not matter whether they are permanent or temporary, resident or visiting, whole time or part time .The hospital authorities are responsible for all of them. The reason is because, even if they are not servants, they are the agents of the hospital to give the treatment. The only exception to the case of consultants or anesthetists selected and employed by the patient himself.[171]

In *Wilsher v. Essex Area Health Authority*[172], a small child who has become blind sued for negligence.The event occurred when, he was amitted in ICU after pre mature birth. A junior Physician inserted the catheter after consulting the methods of insertion with his senior doctor. As a result of the excess supply of oxygen due to the wrong insertion, the child suffered damage to retina causing near blindness. The senior doctor was held liable as the junior doctor has acted under the directions of him.

Indian Courts have reiterated this view. Hospital is liable for the negligence of professional men employed by the authority under contracts for service as well as under contracts of service. The authority owes a duty to give proper treatment medical, surgical and such other services.Even if such services are delegated,the one who is delegating becomes responsible,if that duty be not properly or adequately performed by its delegates.[173] Civil liability of a hospital for injury to a patient may, depending upon the facts, be based upon either the negligence of the hospital entity itself or upon the doctrine of respondeat superior. The hospital's liability is often referred to as corporate negligence.it can be that of providing a defective equipment, improper selection or retention of incompetent personnel, or the failure to exercise the required degree of care in the maintenance of buildings and grounds. The second type of liability is vicarious. The Supreme Court has observed :

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[171] JAGDISH SINGH & VISHWA BHUSHAN,MEDICAL NEGLIGENCE AND COMPENSATION 115-117(2nd ed. 1999)
[172] (1986)3 All E.R. 801
[173] Savita Garg v. National Heart Institute, (2004) 8 SCC 56

> Once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor or hospital. Therefore, in any case, the hospital is in a better position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify and not impleading a particular doctor will not absolve the hospital of its responsibilities[174].

Normally, people are selecting commercially run hospital, owing to their reputation. It is often found that, many hospitals do not provide services up to the mark In case if, it involves some negligence on their part, as per this doctrine, they are bound to reimburse. [175] The principle of '*respondent superior*' is otherwise known as 'captain of the ship' doctrine. As a captain of the ship, the surgeon holds the responsibility for negligent inquiry to the patient while the surgeon is directing the operation[176].It is the exercise of control over others that is the key to the application of this doctrine. Therefore normally a surgeon is not held liable for the negligence of the anaesthetist.[177]At the same time a doctor has a duty to satisfy themselves that the person to whom the task is delegated He should see to it that, the staff whom he is delegating are qualified or have adequate experience, knowledge and skill to discharge the duties which have been delegated to him. If the person who is administering the anaesthesia is incompetent, the in charge surgeon will be held liable for it[178]

The Supreme Court has observed that,

> Once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor or hospital. Therefore, in any case, the hospital is in a better position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of

[174] Balram Prasad v. Kunal Saha & Ors, (2014) 1 SCC 384
[175] *Savita Garg* supra note 173
[176] SINGH & BHUSHAN supra note 171
[177] J.N.Srivastava v.Rambiharilal AIR 1982 MP 132
[178] SINGH & BHUSHAN supra note 171

> care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify and not impleading a particular doctor will not absolve the hospital of its responsibilities. [179]

2.8 . DEFENSES FOR MEDICAL NEGLIGENCE

If the injured party fails to establish existence of essentials of negligence such as duty of care, breach of duty and the casual link between that breach and damage, his action will fail. In other words, it is defence of the defendant which will succeed. But, sometimes, even if the patient succeeds in proving the required elements of tort of negligence, he may lose or damages may be reduced. This occurs when defendant relies on general defence[180].The following defences are available for a physician in medical negligence cases.

2.8.1 CONTRIBUTORY NEGLIGENCE

Contributory negligence is that conduct on the part of the injured party which is below the reasonable standard of care which he needs to exhibit in similar situation. That is, his action is one which is legally contributing to the negligence of the defendant and thereby brings about harm to the plaintiff. Traditionally at common law the plaintiff's contributory negligence totally removes any chance of recovery by the plaintiff for damages[181]

The 1809 English case of *Butterfield v. Forrester*[182] is considered to be the beginning of this concept. In that case, the plaintiff was injured by a fall from his horse when, riding at a fast pace. He ran into an obstruction in the road left by the defendant. It was held that, under these particular circumstances, the plaintiff will be completely denied any recovery due to his contributory

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[179] *Balram Prasad* supra note 174
[180] JONES supra note 137
[181] Harrison v. Montgomery 295 Md. 442, 456 A.2d 894, *Negligence Systems: Contributory Negligence, Comparative Fault, and Joint and Several Liability*, Department of Legislative Services Office of Policy Analysis Annapolis, Maryland January 1-3(2004). http://dls.state.md.us/data/polanasubare/polanasubare_coucrijusncivmat/Negligence-Systems.pdf
[182] 11 East 60, 103 Eng. Rep. 926' (K.B. 1809).
See Fleming James Jr, *Contributory Negligence*, 62 Yale L.J. 691-735 (1953).http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=4112&context=fss_papers.Last visited on 24-09-2016 at 17.17

negligence, even though the defendant's negligent conduct also was a significant cause of the plaintiff's injuries. [183] In *Butterfield*, Lord ELLENBOROUGH, did not bother to have the support any authority.He did not even gave any satisfactory explanation for applying this legal doctrine.[184] As Professor Dan Dobbs has observed:

> This rule was extreme. The plaintiff who was guilty of only slight or trivial negligence was barred completely, even if the defendant was guilty of quite serious negligence, as contemporary courts have had occasion to observe in criticizing the rule. The traditional contributory negligence rule was extreme not merely in results but in principle. No satisfactory reasoning has ever explained the rule. It departed seriously from ideals of accountability and deterrence in tort law because it completely relieved the defendant from liability even if he was by far the most negligent actor.[185]

In America, this doctrine was accepted due to political reasons. It was the time of rise of industrial enterprise. This doctrine, really became significant, due to the convenience it brought.[186]The early 19th century was a time in which known and relatively safe industrial and agricultural techniques were replaced by strange and not yet perfected machinery. The century witnessed a newer kind of growth with potentially dangerous instruments.[187]. The Trains, the steam engines, the saw mill, the cotton gin, and different type of factories, gave the new legal setup good amount of work.[188]The economic developments of this time was marked with the presence of an individualistic political and economic philosophy. This philosophy called for a system favorable to the entrepreneurial class. It wanted to limit the liability of the defendant who was most probably belonged to that class. It had a very strong influence in formation of this principle, which reduced defendant's liability almost to nothing, if a small amount of mistake is found on plaintiff's side.[189] In the words of BLACK, CJ. in

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[183] Peter Nash Swisher, *Virginia Should Abolish The Archaic Tort Defense Of Contributory Negligence And Adopt A Comparative Negligence Defence In Its Place*, University Of Richmond Law Review Vol. 46 359-371(2011).
[184] Swisher supra note 183
[185] DAN B. DOBBS, THE LAW OF TORTS, § 199, at 494–95 (2000) Swisher supra note 183 at 360
[186] James supra note182
[187] *Id* at 692,693
[188] Green, *The Duty Problem in Negligence Cases*, 29 CoL. L RE. 255, 260 (1929) James supra note182 at 695
[189] *James* supra note182 at 695

Railroad Co. v. Aspell[190] "It has been a rule of law from time immemorial, and is not likely to be changed in all time to come, that there can be no recovery for an injury caused by the mutual default of both parties,". The legal thought process had been dominated by the idea that while there may be many causes of an injury in general sense, yet the law should search for a sole or principal proximate cause.[191]According to Judge KELSEY:

> In theory, but hardly in practice, employees in [nineteenth] century factories were protected by their employer's duty ―to provide employees with a reasonably safe place in which to work. Whatever succor this duty provided to employees, it soon surrendered to the ―unholy trinity‖ of employer defenses: contributory negligence, assumption of risk, and the fellow servant rule. They became the ―wicked sisters‖ of the common law because, working together, they effectively nullified any realistic possibility of holding an employer liable for the great majority of on-the-job injuries.[192]

The question which is critical is whether the act of plaintiff was such that, it could expose him directly to the danger which resulted in the injury which he has complained about. If the answer is 'no' then the plaintiff's negligence is considered as contributing to the injury. If the dangers to which he has exposed are something which a person with ordinary faculties can understand, he is assumed to have understood it[193].If the plaintiff by ordinary care could have avoided the effect of negligence of the defendant, he is guilty of contributory negligence, howmuchever negligent the defendant might have been at any of the later stages[194].

Exceptions to contributory negligence

However the judges in the later years have sought to reduce the harsh results of the contributory negligence defence by establishing limits and exceptions to its

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[190] 23 Pa. 147, 149-50 (1854) *Id* at 692
[191] *James* supra note182 at 692,693
[192] D. Arthur Kelsey, *Social Compact as Law: The Workers' Compensation Act and the Wicked Sisters of the Common Law*, VBA NEWS J., Oct./Nov.(2005).
Swisher supra note 183
[193] GOURDAS CHAKRABARTI,THE LAW OF NEGLIGENCE 168-187 (1996)
[194] Turff v. Warmann 2 C.B.N.S.740 *Id* at 171

application. [195] It was set that, for to establishing that the plaintiff has contributed, it must be a proximate cause of injury.

If the plaintiff got scared and confused due to the action of the defendant and in the attempt to save himself faced with the accident and suffered injury, the plaintiff's conduct does not contribute to the injury.[196]similarly the defendants actions if placed plaintiff in a peril, law does not require him to exercise the same degree of care of a normal person who has the full opportunity to make his judgment[197]The defence is usually not applicable when the defendant's conduct is so serious that it constitutes, intentional recklessness.[198] In these situations, the plaintiff is only barred from recovery; if the plaintiff's contributory negligence is similarly aggravated.

Under traditional English and American common law, the "*last clear chance*" doctrine created an exception to the rule. That is,the plaintiff's own carelessness will not bar recovery, if defendant had an opportunity to avoid the accident.. In the 1842 English case *Davies v. Mann*[199], the defendant recklessly drove horses and a the cart into a donkey that had been left fettered in the road. Though the plaintiff had been contributory negligent in leaving the donkey in the highway, the plaintiff was allowed to recover the damages since the defendant had the last clear chance to avoid the collision[200]

The "*last clear chance*" exception provides that when the defendant is negligent and the plaintiff is contributory negligent, but the defendant has "a fresh opportunity (of which he fails to avail himself) to avoid the consequences of his original negligence and the plaintiff's contributory negligence," [201] the defendant will be liable even though, plaintiff contributed to the negligence. Therefore, under a last clear chance exception, the defendant would become

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[195] *Negligence Systems: Contributory Negligence, Comparative Fault, and Joint and Several Liability*, Department of Legislative Services Office of Policy Analysis Annapolis, Maryland January 1-3(2004).
[196] Coulter v. Exp.Co. 56 NV.585 *Id* at *170*
[197] CHAKRABARTI supra note 193
[198] *James* supra note182
[199] 10 M. & W. 546, 548, 152 Eng. Rep. 588 (Ex. 1842).supra note 195
[200] supra note 195
[201] Smiley v. Atkinson, 12 Md. App. 543, 553, 280 A.2d 277, 283 (1971)

responsible for the entire loss of the plaintiff, regardless of the plaintiff's own contribution.

The American Approach

In USA, this principle is applied in different forms in various states. In a Maryland case,[202] the exception allowed to plaintiff injured by sitting on the hood of a running car to recover from the driver. The plaintiff, after being offered a ride up the street, sat on the car's hood. The driver accelerated quickly, throwing the plaintiff to the pavement. Though the plaintiff was held to be contributory negligent, recovery by the plaintiff was still allowed because the defendant had the last clear chance to avoid the accident. Under the law in Arkansas, a party may not recover any amount of damages if the plaintiff's own negligence is calculated to be fifty percent or more. A plaintiff whose negligence is less than 50% can recover from a defendant whose negligence is less than plaintiff's, provided defendants' combined negligence or fault exceeds plaintiffs.[203] Similar rules are existing in other states as well.[204]Plaintiff's failure to use his wisdom and judgment was not accepted as a contributing factor for the negligence of the defendant's employees in failing to whistle or ring a bell at a crossing.[205] With *Alvis v. Ribar*[206], Illinois declared to be the thirty-seventh state to abandon the contributory negligence defense in its strict sense. Under comparative negligence adopted by the Illinois Supreme Court, a negligent plaintiff will be permitted to recover that portion of his damages not attributable to his own fault, and, conversely, a defendant will be liable for only that portion of the damages that he directly caused. In wake of the potentially dangerous

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[202] Ritter v. Portera, 59 Md. App. 65, 474 A.2d 556 (1984)

[203] Walton v. Tull, 234 Ark. 882, 356 S.W.2d 20 (1962), Riddell v. Little, 253 Ark. 686, 488 S.W.2d 34 (1972). See Christy Comstock *Arkansas* ,Sonia Di Valerio,*Comparative/Contributory Negligence Joint and Sevearl Liability*,Commercial Transportation Litigation Committee 8-9 (2009). http://axilonlaw.com/wp-content/uploads/2012/04/50_State_Compendium_-Final_reduced_size.pdf . Last visited on 29-08-2016 at 14.35

[204] *Contributory Negligence vs. Comparative Negligence*, The personal injury Lawyer Directory. (Last visited on 29-08-2016 at 14.42). http://www.the-injury-lawyer-directory.com/negligence.html. (Blog)

[205] Carlson v. R.Co 96 MNN 504,104 NW.555,41,ra.(n.s) 349 113 Am St.Rep.655 .See CHAKRABARTI supra note 193

[206] 85 Ill. 2d 1, 421 N.E.2d 886 (1981).See Carol Isackson, *Pure Comparative Negligence in Illinois,* 58 Chi.-Kent. L. Rev. 599 (1982).

result, most of the states in US have moved from the strict nature of a pure contributory negligence system to some form of a comparative negligence system. Currently, only five states, including the District of Columbia, follow the pure contributory negligence rule[207].

English Law

According to Halsbury's laws of England:

> A distinction must be drawn between children and adults, for an act which would constitute contributory negligence on the part of an adult may fail to do so in the case of a child of young person, the reason being that a child cannot be expected to be as careful for his own safety as an adult. Where a child is of such an age as to be naturally ignorant of danger or to be unable to fend for contributory negligence with regard to a matter beyond his appreciation, but quite young children are held responsible for not exercising that care which may reasonable be expected of them. Where a child in doing an act which contributed to the accident was only following the instincts natural to his age and the circumstances, he is not guilty of contributory negligence, but the taking of reasonable precautions by the defendant to protect a child against his own propensities may afford evidence that the defendant was not negligent, and is, therefore, not liable.[208]

In the case of children, courts have taken serious note of tenderness of age and related infirmities in understanding. Lord Denman in *Lynch v. Nurdin*[209] said:

> Conduct on the part of such child contributing to an accident may not preclude it from recovering in full in circumstances in which similar conduct would preclude a grown up person from doing so ... Negligence means want of ordinary care, and "ordinary care" must mean that degree of care which may reasonably be expected of a person in the plaintiff's situation..

In *Jones v. Lawrence*[210], while dealing with the concept of duty of care by child, Cumming Bruce, J. has held that a child of seven years and three months has

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[207] supra note 204
[208] Halsbury Laws of England, 3rd.ed. Volume 28 at 93,quoted in M.P. State Road Transport v. Abdul Rahman And Ors AIR 1997 MP 248
[209] (1841) 1 Q. B. 29(5), Pearson v. Coleman Bros. (1948) 2 K. B. 359),quoted in Delhi Transport Corporation v. Lalita AIR 1981 Delhi 558
[210] 1970 Acc CJ 358

the propensity to forget altogether what had been talked to him. Therefore, the theory of contributory negligence cannot be applied.[211]

Till the passing of Law Reform (Contributory Negligence) Act 1945, Contributory Negligence was a complete defense in Common Law. This legislation has regulated the application of this defence.It provided for reduction of damages recoverable in case of contributory negligence. The legislation gives the most important direction that the reduction of damage shall not be unfair, unjust, capricious and arbitrary, but it shall be based on equitable principles of justice.[212]

Law in India

Contributory negligence was never accepted as a complete defense in India. High Courts in India dealt this matter in the initial independence years. As back as in 1947, the Calcutta High Court [213] held that "Ordinarily, in case of contributory negligence, there is negligence on both sides, the real test is whether one party could reasonably have avoided the consequences for the other party's negligence. Therefore, in the present case, even mere absence of negligence on the part of the deceased would not be sufficient to justify want of contributory negligence." The Patna High Court made candid observations in *Jang Bahadur Singh v. Sunder Lal Mandal* [214]:

> Contributory negligence implies negligence on both sides. It is a question of fact in each case whether the conduct of the plaintiff amounts to contributory negligence. Furthermore, it is well-settled that in order that negligence of a party may be contributory, it is necessary that it should be the decisive or effective cause of the accident or collision. Therefore, where a party's negligence, even though it continued to the end but did not contribute to the accident, or the collision, which was entirely due to the negligence of the other party, the latter is liable to the former in damages.[215]

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[211] M.P. State Road Transport v. Abdul Rahman AIR 1997 MP 248
[212] CHAKRABARTI supra note 193
[213] Jeet Kumari Poddar v. Chittagong Engineering AIR 1947 Cal 195
[214] AIR 1962 Pat 258
215 Jang Bahadur Singh v. Sunder Lal Mandal AIR 1962 Pat 258

In a similar expression in 1976.[216]:

> This rule of 'last opportunity' obviously failed to give an equitable treatment to the parties concerned because it was based on an illogical postulate that in every case the person whose negligence came last in time was solely responsible for the damage. It took no account of the partial contribution to the unfortunate accident by the other party .

In the instant case the Court observed that, "The question is to what extent she has made this contribution. Answer to this question is necessary because the damages which would eventually be awarded to the petitioner would stand reduced in proportion to her contribution to the accident" Thus not complete bar of recovery but only apportionment was set as a practice in contributory negligence cases."

In *J. Kumari Poddar v Chitagong Engineering and Electrical Supply Co*.[217].it was observed that, "Ordinarily, in case of contributory negligence, there is negligence on both sides, but… the real test is whether one party could reasonably have avoided the consequences for the other party's negligence" Contributory negligence is applicable solely to the conduct of a plaintiff. It means that there has been an act or omission on the part of the plaintiff which has materially contributed to the damage. In India the law is clear that, in a case of contributory negligence, the Courts have the power to apportion the loss between the parties as seems just and equitable. Apportionment in that context means that damage is reduced to such an extent as the court thinks just and equitable having regard to the claim shared in the responsibility for the damage[218]

Contributory Negligence and Medical Care

If the patient has ignored his doctor's advice (for example by discharging himself from hospital contrary to medical advice or failing to return for further treatment) ,contributory negligence is established[219]. It would have to be shown that a reasonable person would have been aware of the significance of the

216 Rehana Kasambhai v.The Transport Manager AIR 1976 Guj 37
217 AIR 1947 Cal 195:
218 *Id*
219 JONES supra note 137

advice, which could depend on the nature of advice given by the doctor and whether the advice and the consequences of not following it, was clear to the patient[220].In one English case, having been told that the result of the 'smear test' is negative, the plaintiff was held to be contributorily negligent for two third of the share in failing to have a further smear test despite frequent reminders[221].

In *Badger v. Ministry of Defence*[222] the patient who continued to smoke cigarettes, knowing that it created a risk of damaging his health was held to be contributorily liable in a claim in respect of lung cancer.

Failure to provide complete medical history or to follow instructions will be a contributing factor in medical negligence cases. Sometimes the unexpected results may not be only due to negligence of the doctor but also due to negligence of patients or relatives. Such situations can be (*a*) Not coming for follow-up as per the advice of doctor; (*b*) Failure to follow the instructions given by the treating doctor; (*c*) Investigations advised by the doctor are not done by the patient; (*d*) Patient fails to take advice of a specialist and he leaves the hospital against medical advice. The liability for the damage in such cases is suitably divided between the doctor, patients and relatives. The burden of proof of contributory negligence on the part of patient is on doctors.[223]

The general view of the physician-patient relationship is based on the assumption that the physician knowledge superior to that of the patient. This assumption is gradually fading over the years and the physician and patient are now placed on practically equal footing.[224] The increased knowledge and awareness of health care issues to the patient is considered by courts also. In *Malay Kumar Ganguly's case*[225] holding the claimant responsible for

[220] Munday v. Australian Capital Territory Health and Community Care Service[2004] ACTSC 134
[221] Pidgeon v. Doncaster Health Authority [2002] Lloyd's Rep.Med.130, Doncaster County Court.
[222] [2006] 3 ALL.E.R 173
[223] Satish K. Tiwari &Mahesh Baldwa, *Medical Negligence*, Indian Pediatrics 488-495, 38 (2001).
[224] Lucinda L. Fraley, *The Evolution and Status of the Contributory Negligence Defense to Medical Malpractice Actions in North Carolina* - McGill v. French, 16 Campbell L. Rev. 103 (1994).
[225] Malay Kumar Ganguly v.Sukumar Mukherjee (2009) 9 SCC 221

contributory negligence, the National Commission deducted 10% from the total compensation .The national commission observed

> …even if we agree that there was interference by Kunal Saha during the treatment, it in no way diminishes the primary responsibility and default in duty on part of the defendants. In spite of a possibility of him playing an overanxious role during the medical proceedings, the breach of duty to take basic standard of medical care on the part of defendants is not diluted. To that extent, contributory negligence is not pertinent. It may, however, have some role to play for the purpose of damages.

2.8.2 ACCEPTED BY A PROFESSIONAL BODY

If a profession embraces a range of views as to what is an acceptable standard of conduct, the competence of the defendant is to be judged by the lowest standard that would be regarded as acceptable[226]. In the words of McNair J. in Bolam's case, [227]"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." Bingham L.J. in Eckersley v. Binnie,[228]summarised the principle as:

> From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members of his profession in knowledge of new advances, discoveries and developments in his field. He should have such awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession n would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet.

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[226] Michael Hyde and Associates v. J.D. Williams & Co. [2001] P.N.L.R. 233,quoted in Jacob mathew
[227] [1957] 1 W.L.R. 582, 586
[228] [1988] 18 Con.L.R. 1, 79

Lord DENNING, expressed in *Hucks v. Cole*,[229] " A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field."In the case of *A.S. Mittal v. State of U.P.*,[230] the Indian Supreme Court took note that the law recognizes the dangers which are inherent in surgical operations and that mistakes will occur, on occasions, despite the exercise of reasonable skill and care[231].

Lord SCARMAN said[232], "Differences of opinion and practice exist, and will always exist, in medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment.

2.8.3 *Volunti Non Fit Injuria*

Volenti non fit injuria means ' no injury is done to one who voluntarily consents'. This is a complete defence to an action in negligence[233]. If a plaintiff, with full knowledge, voluntarily accepts the risk of injury, he or she will not recover any damages. The defendant needs to prove not only that the plaintiff accepted the risk of injury but also accepted that if injury should happen, the plaintiff would accept the legal risk[234].

It consist of a voluntary agreement between the plaintiff and the defendant .By this agreement the plaintiff undertakes to have understood the risk involved in the action of the defendant and consented to it.This will absolve defendant from the unreasonable risk of harm created by him. However, in medical negligence cases, this defence does not apply. The Consent to medical treatment does not mean assumption of the risk. Even in the situation where a patient is told by a doctor that they are inexperienced, it is standard of care which is the determining

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[229] [1968] 118 New LJ 469
[230] AIR 1989 SC 1570
[231] Achut Rao Khodwa v. State of Maharashtra and Ors. AIR 1996 SC 2377
[232] Hunter vs. Hanley 1955 SLT 213
[233] Jennifer Yule, *Defences In Medical Negligence: To What Extent Has Tort Law Reform In Australia Limited The Liability Of Health Professionals?* Journal of the Australasian Law Teachers Association 53-63(2011). http://www.austlii.edu.au/au/journals/JlALawTA/2011/6.pdf . Last visited on 10-07-16 at 23.13.
[234] Smith v Charles Baker & Sons [1891] AC 325; Canterbury Municipal Council v Taylor [2002] NSWCA 24.*Id*

factor of negligence[235]. The patient who consents to medical procedure does not agree to face the risk caused by the doctor's negligence[236].In *Lakshmi Rajan v. Malar Hospital Ltd*.[237]the patient has given consent for removing tumour as she was detected with breast cancer. The surgeon removed her uterus also. The Court held the surgeon liable.

2.8.4 TECHNICAL IMPERFECTIONS

The Supreme Court in *Jacob Mathew case*[238] held that "the standard of care, when assessing the practice adopted is judged in the light of knowledge available at the time (of incident) and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use particular equipment, the charge would fail, if the equipment were not generally available at the point of time at which it is suggested as should have been used"

In *Tarun Thakore v.Noshir M.Shroff,*[239] the operation using laser technology resulted in 'monocular diplopia' .The complainant made a contention that the doctor should have used Lasik Technology instead of PRK (Photo Refractive Keratectomy).The court held that PRK is also a well-recognized method and since at that time Lasik treatment was not largely available, using PRK cannot be considered negligence.[240]

2.8.5 ABSENCE OF PROOF

The standard of reasonable care during the treatment varies from case to case. It is for the complainant to prove negligence by expert evidence or by producing medical literature.[241]Negligence has to be proved. It cannot be presumed.[242]In *Achut Rao Khodwa v. State of Maharashtra and others,*[243], the Supreme Court held that "for establishing negligence or deficiency in service, there must be

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[235] Yule supra note 233
[236] JONES supra note 137
[237] III (1998) C.P.J. 586 (TN)
[238] *Jacob Mathew* supra note 13
[239] 2003 (I) CLD 62 (NC)
[240] RAO supra note 36 at 140
[241] K.S. Bhatia v. Jeevan Hospital and Another ,2004 CTJ 175 (NC) (CP)
[242] Marble City Hospital and Research Centre v. V.R.Soni, 2004 (2) CPJ (!02) (Rajasthan)
[243] AIR 1996 SC 2377

sufficient evidence that a doctor or hospital has not taken reasonable care while treating the patient. Reasonable in discharge of duties by the hospital and doctors varies from case to case…" In *Kiran Bala Rout v. Christian Medical College and Hospital, Vellore,*. [244] The National Commission dismissed complaint on account of lack of proof of negligence. Similarly, in another case, the patient who was an alcoholic, while shifting to ICU jumped out of third floor resulting in multiple injuries. The Commission held that negligence on the part of respondents is not established.

2.9 LEGISLATIVE INTERVENTIONS

Protecting the right to health and health care is the priority for the government and conscious legislative attempts were made in this respect through a number of legislations. However, health regulation in India had always been an intricate issue having various legal political and social concerns. Majority of such legislative interventions were with respect to licensing of medical professionals with a view to control their entry into the market[245]. Statutory regulatory councils have been established to monitor the standards of medical education, promote medical training and research activities, and oversee the qualifications, registration, and professional conduct. Some of the major legislations are,

2.9.1 INDIAN MEDICAL COUNCIL ACT,1956

This legislation was originally enacted for re- constitution of medical council of India and maintenance of a medical register. The Medical Council of India is a statutory body established under the Indian Medical Council Act, 1933 which was later replaced by the Indian Medical Council Act, 1956 (102 of 1956). The main functions of the Council are[246]:

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[244] 2003 CTJ 978 (NC)

[245] Report on the Working Group on Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure For the 11th Five-Year Plan. Government of India Planning Commission.http://planningcommission.nic.in/aboutus/committee/wrkgrp11/wg11_hclinic.pdf Last visited on 14-07-2016

[246] Medical Education, Training and Research,Chapter-6. http://mohfw.nic.in/WriteReadData/l892s/CHAPTER6-67542849.pdf. Last visited 0n 3-10-2016 at 18.24

- Maintenance of uniform standard of Medical education at undergraduate and post-graduate level.
- Maintenance of Indian Medical Register.
- Reciprocity with foreign countries in the matter of mutual recognition of medical qualifications.
- Provisional/permanent registration of doctors with recognized medical qualifications, registration of additional qualifications, and issue of Good Standing Certificates for doctors going abroad .
- Continuing Medical Education, etc.[247].

The Council shall maintain a register of medical practitioners in the prescribed manner, to be known as the Indian Medical Register. It will contain the names of all persons who are for the time being enrolled on any State Medical Register and who possess any of the recognized medical qualifications. It shall be the duty of the Registrar of the Council to keep the Indian Medical Register in accordance with the provisions of this Act and of any orders made by the Council, and from time to time to revise the register and publish it in the Gazette of India. This register is a public document within the meaning of the Indian Evidence Act, 1872.[248] The Council is empowered, with the previous sanction of the Central Government, to make regulations to carry out the purposes of this Act[249].Under this provision, Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 was made. It states duties and responsibilities of doctors as follows.

The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Who – so-ever chooses his profession, assumes the obligation to conduct himself in accordance with its ideals. A physician should be an upright man, instructed in the art of healings.[250] The Principal objective of the medical profession is to render service to humanity with full respect for the dignity of profession and man. Physicians

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[247] *Id*
[248] Section 21 of The Indian Medical Council Act,1956
[249] Section 33 of The Indian Medical Council Act,1956
[250] Section1.1.2 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations,2002.

should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion. Physicians should try continuously to improve medical knowledge and skills and should make available to their patients and colleagues the benefits of their professional attainments. The physician should practice methods of healing founded on scientific basis and should not associate professionally with anyone who violates this principle. The honoured ideals of the medical profession imply that the responsibilities of the physician extend not only to individuals but also to society[251]

2.9.2 DENTIST'S ACT,1948

The Act was enacted to make provision for the regulation of the profession of dentistry and for that purpose to constitute Dental Councils. Dental Council is a statutory body to regulate the Dental education and the profession of Dentistry in India[252]. It lays down standards of profession and ethics including duties and obligations of a Dentist[253].In exercise of the powers given by the Act, the Dental Council of India has made Dentist's (Code of Ethics) Regulation in 1976.It lays down the standards to be followed by practitioners of Dentistry.

2.9.3 TRANSPLANTATION OF HUMAN ORGANS ACT,1994

Organ transplantation was a breakthrough in medical history. Transplantation means the grafting of tissues taken from one part of the body to another part or another individual[254].In order to curb the unethical and uncontrollable trade in human organs, the Transplantation of Human Organs Act, 1994 was passed by the Parliament. Its objective is to provide for the regulation of removal, storage and transplantation of the human organs for the therapeutic purpose and for the prevention of commercial dealings in human organs. It is originally applicable the whole of the States of Goa, Himachal Pradesh and Maharashtra and to all the Union territories and it shall also apply to such other State which adopts this

[251] Section 1.2.1 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

[253] Section 17 A of the Dentists' Act,1948

[254] LILY SRIVASTAVA,LAW & MEDICINE(2010)

Act by resolution passed in that behalf under clause (1) of article 252 of the Constitution.[255]

The Act necessitates that[256]

- The donor must be not less than 18 years and must voluntarily authorize.
- The consent of the donor must be informed
- Removal organ by any person other than a registered medical practitioner is prohibited
- The hospitals engaged in removal, storage or transplantation must be registered.

2.9.4 THE CLINICAL ESTABLISHMENTS (REGISTRATION AND REGULATION) ACT, 2010

The Clinical Establishments (Registration and Regulation) Act, 2010 is, perhaps, the most important public health legislation enacted so far with far reaching effects[257].The Act was enacted by the Central Government to provide for registration and regulation of all clinical establishments in the country with a view to prescribing the minimum standards of facilities and services provided by them. The Act has taken effect in the four states namely; Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim, and all Union Territories except the NCT of Delhi since 1st March, 2012[258]. Other states have a choice of implementing this legislation or enacting their own legislation on the subject[259].The states of Uttar Pradesh, Uttarakhand, Rajasthan, Bihar and Jharkhand have adopted the Act under clause (1) of article 252 of the Constitution[260]. The Act provides for the constitution of a National Council consisting of representatives of Medical Council of India, Dental Council of India, Nursing Council of India, the Pharmacy Council of India, the Indian Systems of Medicines representing

[255] Transplantation of Human Organs Act, 1994
[256] SRIVASTAVA,supra note 254
[257] S.K.Joshi, Clinical Establishments Act, 2010: Salient Features & Critical Analysis,India Medical Times.(Last visited 3-10-2016 at 18.39) http://www.indiamedicaltimes.com/2013/07/10/clinical-establishments-act-2010-salient-features-critical-analysis-by-dr-s-k-joshi/. (Opinion)
[258] The Clinical Establishments (Registration and Regulation) ACT, 2010
[259] S.K.Joshi,supra note 257
[260] supra note 258

Ayurveda, Siddha, Unani and Homoeopathy systems, the Indian Medical Association, the Bureau of Indian Standards, the zonal councils setup under the States Reorganization Act, 1956, the North-Eastern Council, etc.; the function of the National Council shall be to determine the standards for the clinical establishment, classify the clinical establishment into different categories, develop the minimum standards and their periodic review, compile, maintain and update a National Register of clinical establishments, perform any other function determined by the Central Government, from time to time[261].

The Act will be applicable to all clinical establishments (hospitals, maternity homes, nursing homes, dispensaries, clinics, sanatoriums or institutions by whatever name called, that offer services for diagnosis, care or treatment of patients in any recognised system of medicine (Allopathy, Homeopathy, Ayurveda, Unani or Siddha), public or private, except the establishments run by the armed forces.[262]Registration is mandatory for all clinical establishments. No person shall run a clinical establishment unless it is registered.[263]In order to get registered; the establishment has to fulfil the following conditions.[264]

(a) The maintenance of minimum standards of facilities and services and staff, as prescribed[265]

(b) Maintenance of records and submission of reports and returns as prescribed.[266]

The clinical establishment shall undertake to provide within the staff and facilities available such medical examination and treatment as may be required to stabilise the emergency medical condition of any individual brought to any such establishment.[267]

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[261] Section 3 supra note 258
[262] Section 2 supra note 258
[263] Section 11 supra note 258
[264] Section 12 supra note 258
[265] supra note 258
[266] *Id*
[267] Section 13 of the Act

This Act, if implemented throughout the country will give a factual census of the number, category, specialty and location of all the physicians and all the medical establishments of all the systems of medicine in the country[268]. That would be a great achievement as it would be a great help in the countrywide planning and posting of physicians as well as healthcare establishments. Up to now the authorities do not know exactly how many and what categories of doctors are available in different areas[269]. It will also help isolate and identify the hundreds of thousands of quacks that are playing havoc with the lives of millions of people all over the country. Once in place, the system of registration will necessarily help in improving the standards of healthcare establishments within a couple of years[270]. It will also bring about some uniformity in the standards of care across the country[271].

For maximum benefits and uniform effects, ideally the Central Act should have been made applicable in all the states and union territories[272]. However, being a state subject, that is not possible. Since most of the states would be enacting their own legislations, there will be some variation in the provisions from state to state.[273] Another criticism leveled against is that the national council is restricted to government agencies and medical associations. And also, civil society organizations which were responsible for the successful campaign for the enactment is kept away from the functions under the Act.

2.10 LIABILITY FOR NEGLIGENCE

In general, these laws establish councils for prescribing uniform standards for education and qualification of practitioners. And each statute specifically establishes a central registry that will give a complete list of individuals certified

[268] supra note 261
[269] supra note 261
[270] *Id*
[271] *Id*
[272] *Id*
[273] *Id*

to practice the particular field of medicine.[274] Most of them define professional conduct and prescribe standards of it.[275]

Under the Indian Medical Council Act, any complaint with regard to professional misconduct can be brought before the appropriate Medical Council for Disciplinary action.[276] Upon receipt of any complaint of professional misconduct, the appropriate Medical Council would hold an enquiry and give opportunity to the registered medical practitioner to be heard in person or by pleader. If the medical practitioner is found to be guilty of committing professional misconduct, the appropriate Medical Council may award such punishment as deemed necessary or may direct the removal altogether or for a specified period, from the register of the name of the delinquent registered practitioner.[277]

This Act does not give any remedy to the injured party through compensation. The punishments given to the erred doctor by the council does not comfort the complaint in that sense. Therefore as far as civil liability is concerned this legislation is not functional from the patient's point of view. Similarly the Dentist's Act, 1948 also empowers the state Council to take disciplinary action against practitioners who are found to be violating the professional conduct or resorting to unethical practices. However no provision for compensating the victim is included. The Transplantation of Human Organs Act, 1994 which provides for the regulation of removal, storage and transplantation of human organs for therapeutic purposes prescribes authority and restrictions for removal of Human Organs by surgeons. There are Penal provisions against the doctors and hospital for violations of provisions, but the Act does not cover the civil liability part. The Clinical establishments Act, 2010 which is landmark legislation in this arena will revolutionize Indian Health sector, if implemented effectively. The Act provides for monetary penalty for non-registration both for

[274] supra note 245
[275] *Id*
[276] Section 8 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002
[277] *Id*

clinical establishments as well as the doctors working in them. However, compensating the injured patient is beyond the purview of this Act.

2.11 CONCLUSION

In India the vast majority of medical professionals, as well as clinical establishments, are in the private sector which accounts for the large section of healthcare.[278].Therefore the growing number of medical negligence cases raises concern about the effectiveness of law in fixing liability and awarding compensation.

Law of Tort recognizes medical negligence as a specific tort; nevertheless its characteristics have evolved over a period of time. The test of 'ordinary prudent man of his profession' has given way to more stringent standards of reasonable care. Still existence of duty of care, its standard, reasonableness breach and consequential damage, the concepts which forms the foundation of law of negligence are making it abstract and tough for an injured patient to prove. Though there are myriads of legislation in the health care sector, none of them effectively deal with medical negligence and its compensation mechanism.

[278] Sandhya Srinivasan, *Regulation and the Medical Profession Clinical Establishments Act, 2010*, Economic & Political Weekly 14-16 vol. xlviii no 3 January 19 (2013).

CHAPTER III
CONSENT AND INFORMED CONSENT: LEGAL SCENARIO

CHAPTER III CONSENT AND INFORMED CONSENT: LEGAL SCENARIO

3.1. INTRODUCTION

All kinds of medical treatment involve interference with human body. A doctor is required, as part of his duty of care to the patient, to explain what he intends to do, and the implication involved, in the way in which a responsible doctor in similar circumstances would have done, and if there is a real risk of misfortune inherent in the procedure, however well it is carried out, the doctor has a duty to warn of the risk of such misfortune[279].

Any therapeutic or investigative procedure without consent is technically an offence. It can be either under Tort (civil) or Criminal law[280]. Under Civil law, a non-consensual interference in to body of a person can be either "assault" or "battery". It comes under the heading "trespass to the person".

3.2. CONSENT UNDER LAW OF TORT

Law of Tort uses the word 'trespass' to refer to the direct interference with a person's body or liberty. In its original legal meaning it signified no more than 'wrong'.[281]Trespass was so called from the name of the writ which commences it- writ of trespass.[282] The writ was intended to provide effective remedies for persons aggrieved by violent injuries to person and property [283] .It was considered as a breach of king's peace and used to be dealt by the king's courts. In the course of time 'trespass' has got a wider meaning covering injuries to land, to goods and to persons.[284]As, its jurisdiction widened, the writ became popular as an instrument for protection against powerful malefactors.[285]

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[279] Chatterton v. Gerson [1980]1 BMLR 80 (QBD))
[280] Karunakaran Mathiharan, *Law on Consent And Confidentiality In India: A Need For Clarity*, The National Medical Journal Of India Vol. 27, No. 1, (2014).
[281] ROGERS supra note 35 at 97-98.
[282] A LAKSHMINATH & M SRIDHAR (ed.) RAMASWAMYIYER'S THE LAW OF TORTS, 16-18 (10th ed.2010).
[283] *Id* at 16
[284] ROGERS supra note 35 at 97-123.
[285] LAKSHMINATH & SRIDHAR ,supra note *282*

Trespass to the person can be in three main forms, assault, battery and false imprisonment. All the three has a common element that it must be committed by direct means[286].The principle is that any direct invasion of a protected interest from a positive act is actionable as trespass subject to justification[287].If the invasion is indirect or from an omission as distinguished from a positive act, there could be no liability for trespass, though the wrong doer might have been liable in some other form of action. If the invasion is unintended, though direct and resulting from a positive act, three will still be no liability, if the conduct of the defendant was reasonable.[288]However, liability for trespass arises even if it was reasonable ,if the invasion was a foreseeable consequence. In *Fowler v.Lanning*,[289]the plaintiff claimed damages for trespass to the person and it was alleged that the defendant shot plaintiff on a particular date at a particular place. Holding that the statement of claim did not disclose a course of action, DIPLOCK, J. expressed that trespass to person will not lie if the injury to the plaintiff, although the direct consequence of the act of the defendant, was caused unintentionally and without negligence on his part. And the onus of proving intention or negligence is on the part of the plaintiff[290].

3.2.1. ASSAULT

Assault is an act of the defendant which causes the plaintiff reasonable apprehension of the infliction of a battery on him by the defendant.[291]Assault does not require contact. Its essence is conduct which leads the plaintiff to apprehend the application of force. In majority cases assault proceeds battery. But there are cases where the plaintiff had no opportunity of experiencing any apprehension before the force is applied.[292]Assault is a tort and a crime like battery, due to its tendency to breach the peace.Inoder to raise an action for assault, the plaintiff must prove that there was some gesture or preparation

[286] ROGERS supra note 35
[287] JUSTICE G. P.SINGH (ed.),RATANLAL & DHIRAJLAL ON LAW OF TORT, 255-260 (26th ed.2012)
[288] *Id* at 255
[289] (1959) 1 QB 426
[290] SINGH supra note *287*
[291] ROGERS supra note 35
[292] *Id*

which constituted a threat of force. The gesture or action must cause a reasonable apprehension of force. And assault must be intentional.[293]

3.2.2. FALSE IMPRISONMENT

False imprisonment means the total restraint of a person's liberty without lawful justification. Every restraint of liberty of one person by another is in law an imprisonment and if it is imposed without a lawful cause, it is false imprisonment. False imprisonment is a tort and it used to be followed with force or threat of force, it was regarded ,in early times as assault or battery[294]A mere restraint or obstruction of movement in one direction is not imprisonment and actionable as such. It is however a crime and actionable by reason of damage resulting from it.[295]

3.2.3. BATTERY

Battery is the intentional application of force to a person without lawful justification. Battery need not be accompanied by a physical harm.[296]The mere use of force is considered as unlawful on account of the insult to the dignity of the person and its tendency to cause a breach of peace.[297]A battery includes an assault which is briefly stated is an overt act, evidencing an immediate intention to commit a battery. Physical contact is necessary to accomplish battery.[298]In an action for battery the plaintiff must prove, first the use of force to him. It may be directly to his body, e.g., slapping, pushing, bringing an object in contact like, setting a dog or throwing a stone at him .It may also be to objects in contact with him, eg.touching his coat, upsetting the carriage on which he is seated or whipping a horse on which he is riding causing it to throw him off[299].

Battery requires actual contact with the body of another person, so seizing and laying hold of a person so as to restrain him[300] ,taking a person by his

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[293] LAKSHMINATH & SRIDHAR ,supra note *282*
[294] *Id*
[295] Section 339 of Indian Penal Code
[296] LAKSHMINATH & SRIDHAR ,supra note *282*
[297] *Id* at 49-54
[298] SINGH supra note *287* at 256-275
[299] SINGH supra note *287* at 256-275
[300] Rawling v.Tull (1837) 3 M KW 28.

collar,[301]causing another to be medically examined against his/her will[302] are held to amount to battery. A physical contact with the body of the person or his clothing is sufficient to amount to 'force'.[303]There is battery if the defendant shoots the plaintiff from a distance just as much as when he strikes him with his fist .similar is the case when defendant deliberately runs into the car in which plaintiff is sitting, shaking him up.[304]

The use of force must be intentional and without lawful justification. Jostling another unintentionally in a crowd is not, but doing it deliberately will amount to battery. [305] An injury inflicted by an instrument held in hand is not; nevertheless a strike by a missile is a battery.[306]Throwing water on another is assault, and falling a drop upon him, will make it battery[307].

In the words of HOLT, C J, the least touching of another in anger is battery[308].However hostility as a test to distinguish battery from a legally un objectionable contact will be too narrow. In practical situation an unwelcomed kiss is as much actionable as a blow which need not necessarily stem from 'anger'.[309]ROBERT GOFF L.J. said in *Collin*'s case that, quite apart from specific defenses such as lawful authority, bodily contact was not actionable if it was generally acceptable, in ordinary conduct of everyday life.[310] It was held that battery involves a 'hostile' touching. However that hostility did not require ill will or malevolence. [311] The central idea is that the interference must be 'offensive' in the sense that, it infringes the claimant's right to be physically inviolate, to be 'let alone'.[312]

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[301] Wiffin v. Kincard (1807) 2 B & PNR 471
[302] Latter v. Braddell (1881) 28 WR (Eng) 239
[303] ROGERS supra note 35
[304] Clark v. State ,746 So 2d 1237 (Fla.1999)
[305] Cole v. Turner (1704) 6 Mod 149
[306] SINGH supra note *287*
[307] Pursell v. Horn, (1832) 3 N & P 564, 8, A & E 602
[308] *Cole* supra note305
[309] ROGERS supra note 35
[310] Collins v. Wilcock [1984] 1 W.L.R. 1172
[311] ROGERS supra note 35
[312] *Id*

3.2.4. CONSENT AND BATTERY

Where there is consent, there is no battery and the same is true where the plaintiff, though not in fact consenting, so conducts himself as to lead the defendant reasonably to believe that consent exists.[313] Consent, expressed or implied is a lawful justification.[314]It may be implied from the situation or relationship of parties e.g., friendly push or shaking hands.[315] Subject to lawful authority, such as power of arrest, an adult of full understanding has an absolute right to the inviolability of his body and therefore has an absolute right to choose whether or not to consent for medical treatment.[316]

It is battery to administer medical treatment to an adult, who is conscious and of sound mind, without his consent.[317]If an adult person of sound person refuses to consent to a medical treatment, it should be adhered to even though it is not in the interest of the patient.[318]There are defenses also such as situations of emergency where an urgent action is imperative in the interest of the patient, and because the patient is unconscious or for some other reasons consent cannot be obtained unless too late[319].Necessity also is a defence.In case of patients who are in a persistent vegetative state, subject to stringent requirements of both law and medical profession, consent may not be insisted upon[320]

3.2.5. CONSENT UNDER CRIMINAL LAW

Under the criminal law, consent can be a defense, if given by an adult who is sound mind. Physical interference without consent in the absence of legal authority constitutes an offence.[321]This concept is derived from the maxim *volunti non fit injuria* (he who consents suffers no injury).it is founded on the two prepositions,(a) every person is the best judge of his own interest and (b)

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[313] ROGERS supra note 35
[314] LAKSHMINATH & SRIDHAR ,supra note *282 at* 49-51
[315] Tuberville v. Savage (1669) 1 Mod 3
[316] ROGERS supra note 35
[317] Re F(Mental patient: Sterilisation) [1990] 2AC
[318] LAKSHMINATH & SRIDHAR ,supra note *282* at 49-51
[319] Airedale,MHS Trust [1993] 1 All ER 821
[320] LAKSHMINATH & SRIDHAR ,supra note *282*
[321] P. M. Bakshi, *Consent To Surgery*, J.T.R.I. Issue – 2,(1995). http://ijtr.nic.in/articles/art8.pdf .Last visited on 4-10-2016 at 14.41

no man will consent to what he thinks hurtful to himself.[322] Under civil law, no suit can be brought in consequence of anything done or arising of what is done with the consent of the person complaining it.Consent is a complete answer in such suits. In criminal law it is different. Acts are punished as crimes, because it is in the interest of the society that they should be prevented. Consent of the immediate sufferer is immaterial, if the injury to society remains.[323]

3.2.6. USE OF CRIMINAL FORCE

Intentionally using force to any person, without that person's consent, in order to or intending to commit any offence is use of criminal force.[324]Use of criminal force will be aggravated in the light of the person on whom force is used (e. g. public servant or woman) or other circumstances. When it is a criminal offence, the indictments are framed under the penal code [325].Use of force must be intentional. The definition of criminal force contemplates the force being used against a person and not against a matter or a substance. The force must be used without consent. Mere submission by one who does not know the nature of the act done cannot be consent. The force must have been used with the intention of committing an offence or to cause or knowing it to be likely to cause injury, fear or annoyance to the person to whom the force is used. If the use of force results in a wound, then the offence will be termed "hurt" or "grievous hurt" be either "assault" or "battery". In case of death, various categories of homicide become relevant In India.

3.2.7. USING CRIMINAL FORCE

In a charge of assault, consent can never be a defense when the alleged assault consists of an unlawful act.[326] Sections 87 to 92 of the Indian Penal Code are significant in this respect. These sections are significant in determining the

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[322] S.K.SARVARIA (ed.), R.A NELSON'S INDIAN PENAL CODE, 642 -646 (10th ed.2008).
[323] *Id*
[324] JUSTICE C.K.THAKKAR(ed.) RATANLAL& DHIRAJLAL LAW OF CRIMES, 1740-1759(25th ed. 2004)
[325] Bakshi, supra note 321
[326] THAKKAR, supra note 324

question how far consent is necessary and sufficient to legalize invasive action.[327]

A person above 18 years of age can give valid consent to suffer any harm, which may result from an act not intended or not known to cause death or grievous hurt[328]. Similarly an act is lawful, if it is done with valid consent of an adult ,in good faith for his/her benefit, not intending to cause death[329].An example is given about a surgeon operating his patient with his consent in good faith, knowing that such an operation is likely to cause patient's death. Also, a guardian can give valid consent to inflict any harm that may result from an act, not intended or not known to cause death, done in good faith and for the benefit of a child below 12 years of age or an insane person[330].At the same time law is very clear about a consent not being valid, when it is given under fear or misconception[331].An act which is independently is an offence will not be justified, just because it is done with the consent of the sufferer[332].However criminal law system protects, actions done in good faith ,for the benefit of the sufferer, even without consent, in case of emergency. In criminal procedure, it shall be lawful for a registered medical practitioner, acting at the request of a police officer not below the rank of sub- inspector to make an examination of the person arrested, and to use such force as is necessary for that purpose.[333]Pain or torture for the purpose examination is allowed by law[334].Even reasonable force can be used even though ,it may cause discomfort[335].Examination shall include the examination of blood , sweat,hair,finger nails etc.as in the case may be. DNA evidence is now a predominant forensic technique for identifying criminals when biological tissues are left at the scene of crime.[336] A criminal court can make a direction for blood test to be taken by taking blood sample of

[327] Bakshi, supra note 321
[328] Sec 87 IPC
[329] Section 88 of IPC
[330] Section 89 of IPC
[331] Section 90 of IPC
[332] Section 91 of IPC
[333] Section 53 of Cr.P.C.
[334] JUSTICE Y.V CHANDRACHUD & V.R.MANOHAR,(ed.)RATANLAL & DHIRAJLAL THE CODE OF CRIMINAL PROCEDURE (ACT II OF 1974), 111 -117(18th ed.2006).
[335] Ananth Kumar v.State of A.P.,1977 Cr.L.J 1797 (A.P)
[336] CHANDRACHUD & MANOHAR, supra note 334

the complainant, accused and of the child .But an order to submit to blood test which involves insertion of needle in the veins of a person, is an assault, unless consented to. It would need express statutory authority to require a person to submit to it.This is based on the fundamental principle that human body is inviolable and no one can prick it.Where a court makes a direction for blood test and the accused fails or refuses to comply with it, the court can use such failure or refusal as corroborative evidence against him.[337] .

3.3.CONSENT UNDER CONTRACT LAW

Section 13 of the Indian Contract Act lays down that two or more persons are said to consent when they agree upon the same thing in the same sense (*consensus ad idem*)[338] And Section 11 states that every person who is of the age of majority is competent to contract. According to the Indian Majority Act[339] every person attains the age of majority on his completing the age of 18 years.[340] Consent is free when it works without obstacles to impede its exercise. Consent is said to be free when it is not caused by co-ercion, undue influence, fraud, misrepresentation or mistake. Consent can be regarded as informed when it is an act of reason accompanied with deliberations of a mind which knows right from wrong, good and evil and it postulates an active will on the part of the person giving consent to permit the doing of the act complained of with full knowledge of the act that is being done and the rights and obligations of the parties involved in the commission of the act. Where Consent was given on the strength of a representation, which, when made, was not intended to be rally acted upon, it was held to have been obtained upon a misrepresentation.[341]

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[337] CHANDRACHUD & MANOHAR, supra note 334
[338] Anil Chaturvedi, *Consent — Its MedicolegalAspects*,Chapter153,medicine updates.http://www.apiindia.org/pdf/medicine_update_2007/153.pdf Last visited on 4-10-2016 at 15.00.
[339] Sec 3 (1)
[340] Mathiharan,supra note 280
[341] NILIMA BHADBHADE (ed.)POLLOCK & MULLA THE INDIAN CONTRACT AND SPECIFIC RELIEF ACTS, 321-323 (14th ed.2013).

3.3.1. DUTY OF DISCLOSURE

In common law, there is no general duty of disclosure of material facts before the contract is being made.[342] For example a bank has no duty to inform its customers that a more attractive rate of interest is available on a different account. This reflects a major difference between common law and civil law, since in most civil law systems a party who deliberately does not disclose material facts to the other party may be liable for fraud.[343]

3.3.2. CONTRACTS OF '*Uberrimae Fidei*'

Contracts of *uberrimae fidei* are those of utmost good faith. They may be avoided unless there has been a full disclosure of all material facts. In certain classes of contracts, one of the parties is presumed to have means of knowledge which are not accessible to the other. The party who is presumed to have the information is therefore bound to disclose all information which is likely to affect the judgment of the other party. Contracts of insurance are of this type. In another case, certain contractual relations are not purely commercial in nature, but one of trust and confidence and one of dependence which imposes upon the party in whom confidence is reposed, a duty to make disclosure.[344]

3.4 CONSENT AND MEDICAL NEGLIGENCE

A doctor's duty of reasonable care involves giving the patient, a description of his conditions and appropriate course treatment including the risks.[345] If there is a probability of the treatment producing results, which are harmful to patient, those factors must be weighed by the doctor, before he recommends the treatment. The patient is entitled to consider and reject the treatment and for that purpose,it is necessary to understand doctors' advice and the possibility of harm resulting from the treatment including surgery.[346] In the medical negligence

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[342] J.BEATSON(ed.),ANSON'S LAW OF CONTRACT, 263- 265 (28TH ed.2002)
[343] *Id*,quoting LANDO AND BEALE,PRINCIPLES OF EUROPEAN CONTRACT LAW
[344] BEATSON ,supra note 342
[345] R.K BAG,LAW OF MEDICAL NEGLIGENCE AND COMPENSATION,(2nd Edition,2001).
[346] Sidaway v.Bethlem Royal Hospital Governors [1985] AC 871;[1985]1 All ER 643

cases, negligence usually means that diagnosis, advice or treatment was carried out carelessly or improperly or without adequate technical skill, and the injury which resulted was avoidable with proper diagnosis, advice or correctly performed treatment[347]. In the cases under consideration, the injury arises not from an inadequately performed medical procedure but from a risk inherent in a treatment adequately carried out, a risk known to the doctor but not disclosed to the patient.[348] Harm is caused by the inadequate information because, had adequate information been given, the patient would not have agreed to the treatment which resulted in the injury.[349]Thus, a claim in negligence requires the plaintiff to prove that the doctor's general duty of care includes an obligation to inform of certain risks, a breach of that duty by not informing of those risk and harm caused by that breach because injury resulted from a procedure or treatment the patient would not have agreed to had the true risk been disclosed.[350] The significant question is whether 'the doctor, in the disclosure or lack of disclosure which has occurred, acted reasonably in the exercise of professional skill and judgment or not?' In determining the what information must be given, variables such as the age of the patient, the mental, emotional and physical condition of the patient, the physician's judgment as to the treatment needs of the patient, the patient's questions or denial of desire for information, the nature of the risk, the seriousness of harm and its likelihood of occurrence, and the nature of the proposed medical procedure ,are included.[351]

In Allan's[352] case, the anesthetic was administered by an injection into vein in patients left arm. The drug leaked into the tissue of the arm and the needle slipped during operation. The patient suffered sudden and unexpected reaction. The doctor was not held liable in negligence, since such mode of administration of anesthetic drug was an accepted medical practice.Morover such leakage was an expected risk of the procedure. But the doctor was held liable for battery,

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[347] Kathleen Mack,*The Impact Of The Consent To Medical And Dental Procedures Act 1985 (SA) on Common Law Principles of Informed Consent In South Australia*, 11 ADEL LR(1988).
[348] Mack supra note 347
[349] *Id*
[350] *Id*
[351] *Id*
[352] Allan v. New Mount Sinai Hospital (1980) 109 DLR (3d) 634 reversed (1981) 125 DLR(3d) 276, BAG supra note 345

since the patient expressly prohibited the doctor from administering anesthetic to her left arm. This decision made a loud statement that the physician who does not care to obtain consent of the patient will be liable even if he undertakes a practice which is accepted by his own professional body. However the decision was reversed by the Court of appeal on the ground that the patient has not pleaded battery. In a resembling case, a woman consulted a doctor for an aliment which required minor gynecological surgery. The surgeon, while performing that surgery discovered that the woman's womb was ruptured. He sterilized her there and then. The patient had not agreed to sterilization. The doctor was held liable for unauthorized interference with patient's body.[353] The concept of patients autonomy suggest that a competent adult has every right to choose the mode of treatment and reject one even if it may appear to be wrong in the eyes of the physician.[354]

3.4.1 ELECTIVE SURGERY

The law expects a doctor to inform the patient about the inherent risks involved in the medical intervention.Therfore he has to do this for obtaining consent of the patient in such a way that a reasonable physician would have done in his situation. The common risks involved in a surgery which is essential for continued good health may not be necessary. But in case of surgeries which are not essential, such as sterilization, cosmetic surgeries, the physician is expected to inform about the common risk also[355].The liability of physicians in case of absence of disclosure of information will be determined according to the set standards of negligence in the accepted medical practice.[356] In *Manual Ben*'s case[357] the patient had undergone dilation and evacuation operation for termination of pregnancy. The surgeon who conducted the operation removed uterus for saving patients life. It was held by the state commission that the surgeon has acted in such a way that any responsible person of his profession would have performed in his position. The doctor was held not liable as it was

[353] Devi v. West Midlands AHA, (1980)7 C. L. 44.
[354] BAG supra note 345
[355] Videto v. Kennedy (1980) 107DLR (3d 612), BAG supra note 345
[356] Cold v.Haringey Health Authority[1988]QB 481(r.k.Baug)
[357] Manjulaben Patel v. Harshida Patel 1997(3) CPR 264

an emergency surgery to save patients life. The Courts in India have held surgeon liable for performing sterilization during caesarian section without consent, when it is not to save the life of the mother or in an emergency[358].It was held by State Commission ,Tamil Nadu[359] ,that the consent given by the patient for abdominal hysterectomy has no validity, since she is not capable of understanding the medical terminology, in a situation, where such surgery was not a necessity[360]

3.4.2 RIGHT TO REFUSAL

The patient has right to protect his own body from outside interference. The tort of battery establishes the concept that any non-contentious touch which is harmful or against the reasonable sense of dignity is actionable. When a medical man advances the pea that a patient refused to follow his prescription for treatment or advice for surgery, the duty is on the physician to prove that the absence of treatment or non-performance of surgery was on account of patients refusal[361]. A practical question that may arise Is. whether (a) it is for the patient to prove that he did not agree to the medical or surgical procedure in question, or (b) whether it is for the doctor to prove that the patient gave his consent. A High Court judge in England has taken the former view[362]. Indian courts have taken different views based on facts of each case. No doubt, consent may be implied and therefore a court may presume that up to a certain limit, implied consent was given. But beyond that, specific proof may be required in each case. In India, the burden of proof lies upon the doctor to justify an action which would be illegal in the absence of consent[363].

In 1992,it was held in England,that the court would exercise its inherent jurisdiction to authorize the surgeon to carry emergency caesarian section in order to save the life of an unborn child contrary to patients belief and refusal[364]

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[358] Janaki Kumar v.Sarafunnisa 1999(3) CPR 472(Ker)
[359] Lakshmi Rajan v.Malar Hospitals 1997(3)CPR 90 (Chennai)
[360] BAG supra note 345
[361] Thomas v..Elisa AIR 1987Ker.52
[362] Freeman v. Home Office (1984) 2 W. L. R. 130.
[363] Sections 101 to 105 Indian Evidence Act,1872
[364] Re,S [1992]4 All ER 671

But later in 1997,in another case[365], a child was born with a defective liver. Doctors were of the opinion that with a liver transplant, this can be rectified and it is most probable that the child will have many years of normal life. The mother of the child refused to give consent for the treatment. Under the ward ship jurisdiction the judge gave permission to perform the operation. Reversing this decision the Court of Appeal held that, the mother being the natural guardian her views were relevant and the trial judge erred in giving a permission overriding the parent's refusal.

When a surgeon or medical man advances a plea that the patient did not give his consent for the surgery or the course of treatment advised by him, the burden is on him to prove that the non-performance of the surgery or the non-administration of the treatment was on account of the refusal of the patient to give consent thereto. This is especially so in a case where the patient is not alive to give evidence. Consent is implied in the case of a patient who submits to the doctor and the absence of consent must be made out by the person alleging it[366].

3.4.3 WAIVER

An attitude of the patient or parents/guardian, where they wish not to have information that might unduly distress them, and leave the decision on the physician must be honored and this is called 'waiver of consent'. Indian patients who are poor, underprivileged, with low education levels have blind faith in the doctors and believe the best of treatment will be offered to them or their child. Such waiver of consent should be documented in medical records, and preferably should be in the form of signed proforma.[367]

3.4.4 MINOR'S CONSENT

Section 3 of Indian Majority Act, 1875, sets the age of majority as 18 years in India.Therfore a person who has not completed 18 years is minor. The age of consent is bound by legal definitions and within the context of the Indian law;

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[365] *Re,*T(a minor)(wardship: medical treatment) [1997]1 All ER 906(CA)
[366] Thomas v.Alisa AIR 1987 Ker 52
[367] Kaushik et al., *Informed Consent in Pediatric Practice*, Indian Pediatrics, Volume 47 December 17(2010).

there are two schools of thought. Indian Penal Code states that consent by intoxicated person, person of unsound mind or a person below twelve years of age is invalid[368]. According to the Indian Contract Act of 1872 – a competent person of sound mind who has attained the age of majority that is 18 years can only ,legally enter into a contract. Then the question is about the validity of consent given by a person who is above 12 year and below 18 years. As per Hindu law, the natural guardian or the guardian appointed by the court has authority to give consent for medical treatment, including surgery on behalf of the minor.[369]In Common-law natural guardian is authorized to do all acts which are necessary or reasonable in the best interest of the minor. The child's power to give consent for medical treatment is concurrent to that of the parents[370] and a parental consent may render lawful treatment to which the child objects, though no doctor can be compelled to administer treatment and in deciding whether or not to do so he will be influenced by the child's wishes. When the child has the capacity to give valid consent and does so, parent's objection to the treatment will not invalidate child's consent.[371]

3.4.5 MEDICAL TERMINATION OF PREGNANCY

The circumstances under which Medical Termination of Pregnancy (MTP) can be performed, the places where it can be conducted, the qualifications, experience and training of personnel who can conduct the MTP, the conditions for approving places, and recording and reporting procedures, etc., are specified under the Medical Termination of Pregnancy Act, 1971, and the MTP Rules and Regulations of 1975.

A girl under 18 years of age cannot give valid consent to undergo medical termination of pregnancy. Pregnancy of a minor cannot be terminated except with written consent of her guardian.[372]Parental consent is essential in case of a

[368] Section 90 of IPC
[369] Section 4,24 of Guardian and Wards Act,1890, Section 4 of Hindu Minority and Guardianship Act 1956
[370] R,Re [1992] Fam. 11 ROGERS supra note 35.at 104-121
[371] R,Re [1993] Fam.64 ROGERS supra note 35.at 104-121
[372] Section 4(a) of Medical termination of Pregnancy Act,1971

minor or a lunatic, and the provision ensures that no pregnancy shall be terminated without the consent of the woman.

In Gilliks case[373] it was held that a minor can also give valid consent, if minor is capable of sufficient intelligence and power of understanding about the proposed procedure. This can be read along with the fact that In India, all persons are considered competent to testify, unless the Court considers that they are prevented from understanding the questions put to them, or from giving rational answers to those questions, by tender years, extreme old age, disease, whether of body or mind, or any other cause of the same kind[374]. A child witnesss is allowed to testify if he is capable of understanding the questions put to him and answer rationally. But the capability is subjective and is a matter of fact to be determined based on the evidence produced before the court[375]. It may be mentioned that according to recent trends, the wishes of a child who is below 18 years of age but who is mature enough to understand such matters have to be taken into consideration.[376] In *V. Krishnan's* case[377], the Madras High Court held that a father cannot compel his daughter of 16 years to undergo abortion. It has to be understood that a person above 12 years of age can consent to medical/surgical/dental treatment , if it is intended for their benefit and undertaken in good faith.[378]

In case of emergency, when parents/guardians are not available to consent, a person in charge of the child like principal or school teacher can consent for medical treatment (*loco parentis*)[379].For children who are orphans or unknown or street children, the court is appointed as a guardian and any procedures/treatment requires court permission.[380]. An act done in good faith for benefit of a person less than 12 years of age by consent, either express or

[373] Gilick v. West Norfolk and Wisbeeli AHA. (1985) 3 All.E.R. 402
[374] Section 118 of Indian Evidence Act,,1872
[375] Section 4 of Guardian and Wards Act,1890, Section 4 of Hindu Minority and Guardianship Act 1956 Mathiharan,supra note 280.
[376] Bakshi, supra note 321
[377] V. Krishnan v. I.G.Rajan, (1994) Law weekly (Crim.) 16
[378] Kaushik et al.,supra note 367
[379] Kaushik et al.,supra note 367
[380] *Id*

implied, by the guardian or other person having lawful charge is not an offence by reason of any harm. This exception is not available if there is an intention to cause death or grievous hurt. In emergency situations, where there are no guardians/parents from whom it is possible to obtain consent, one can proceed to save the life of the child[381].

3.4.5 BLOOD TEST AND TRANSPLANTATION OF ORGANS

A person cannot, in the absence of statutory authority, be subjected to blood tests. In *Gautama Kundu's* case[382], , It was held that no one can be subjected to blood test against his wishes for determining paternity and the court has no such power to order blood test where no statute exists to give such authority. Courts in India cannot order blood test as a matter of course. Unlike the English law in India there is no special statute governing this. Neither in the Criminal procedure Code nor the Evidence Act empowers the court to direct such a test[383].In the case of persons accused of offences, physical examination of the body including pathological tests, have been authorized.[384]

Transplantation means the grafting of tissues taken from one part of the body to another part or another individual [385] .In order to curb the unethical and uncontrollable trade in human organs, the Transplantation of Human Organs Act,1994 was passed by the Parliament. Its objective is to provide for the regulation of removal, storage and transplantation of the human organs for the therapeutic purpose and for the prevention of commercial dealings in human organs. Removal of any organ for therapeutic purposes from a living person is authorized.[386]It is required that a live donor of human organ must have given his voluntary consent to transplantation of an organ from his body.[387] If the person is above 18 years, conscious and of sound mental health his/her own consent is required for removal of organs from his/her body .Therefore, it is

[381] Section 92 IPC
[382] Goutam Kundu v. State of West Bengal 1993 AIR 2295
[383] *Goutam Kundu* supra note 382
[384] Section 53, Code of Criminal Procedure, 1973
[385] LILY SRIVASTAVA,LAW & MEDICINE(2010)
[386] Section 3 The Transplantation of Human organs Act, 1994
[387] Section 3 (1) of TheTransplantation of Organs Act (42 of 1994

illegal to remove of organs from the body of a person of less than 18 years even with his/her consent.[388]

The Act necessitates that.[389] the donor must be not less than 18 years and must voluntarily authorize. Most importantly, consent of the donor must be informed.

3.5 EXCEPTIONS

In *Thomas v. Alisa,*[390] the High Court observed that:

> As a general rule, medical treatment, even of a minor nature, should not proceed unless the doctor has first obtained the patient's consent. This consent may be expressed or it may be implied, as it is when the patient present himself to the doctor for examination and acquiesces in the suggested routine. The principle of requiring consent applies in the overwhelming majority of cases, but there are certain circumstances in which a doctor may be entitled to proceed without this consent -- firstly, when the patient's balance of mind is disturbed, secondly, when the patient is incapable of giving consent by reason of unconsciousness; and, finally, when the patient is a minor.

The following are such cases where law allows the doctor to act without consent.

3.5.1 MENTALLY ILL PERSONS

Mentally ill person means a person who is in need of treatment for any mental disorder, other than mental retardation.[391] People with mental disorders are particularly vulnerable to abuse and violation of their rights.[392]There are more excuses for violation of individual autonomy and forced treatment due to the very absence of mental ability. Mental Health Act, 1987 is silent regarding the consent for treatment, and the method to be adopted when a severely ill patient refuses well established treatments like medication or modified electroconvulsive therapy.[393] Hospitals at their level try to evolve some uniform

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[388] Chaturvedi supra note 338
[389] SRIVASTAVA supra note385
[390] AIR 1987 Ker 52
[391] Section 2(1) of Mental Health Act,1987
[392] WHO Resource Book on Mental Health, *Human Rights and Legislation* (2005). http://ec.europa.eu/health/mental_health/docs/who_resource_book_en.pdf. Last visited on 24-07-2016 at 16.46.
[393] Math et al., Mental Health Act (1987): Need for a paradigm shift from custodial to community care 246-249 Indian J Med Res 133 (March 2011).

standards for taking decisions on behalf of a patient unable to consent. One suggested method is to obtain the opinion of two psychiatrists independently and also the consent of the hospital RMO or superintendent who acts as a surrogate guardian.[394]

3.5.2 EMERGENCY TREATMENT

In case of emergency, the well-being of the patient is paramount and medical rather than the legal considerations come first.[395] Generally it is essential to obtain consent before any treatment is administered. However, there is an important exception to the rule. In cases of emergency a patient may be unable to give consent, in such cases a substitute decision maker, can give the consent. If however such a person is not on the scene, then it is the duty of the doctor to do what is essential to save life even without consent.[396]A doctor can give treatment, including surgery to adult patients who are unable to give consent, in an emergency, provided such treatment is performed in the best interest of the patient. Similarly in a life threatening situation the doctors need not consult the parents of minor patients.[397]The doctor has the authority to perform any mode of treatment as is necessary, in the best interest of the patient, in an emergency situation whether it is based on 'implied consent' or ' agency by necessity'. Section 92 of the IPC offers legal immunity to a registered medical practitioner to proceed with appropriate treatment even without the consent of the patient in an emergency when the victim is incapable of understanding the nature of the treatment or when there are no legal heirs to sign the consent. If the patient is conscious and refuses treatment without which that person might endanger his/her life, then the surgeon can inform the judicial magistrate and get the sovereign power of guardianship over persons under disability (*parens patriae*).[398] In a case, the surgeon did not explain the hazards of chloroform anesthesia before taking consent of the patient for operation of appendicitis. Finding the appendix to be normal, he proceeded to remove the gallbladder

[394] Math et al supra note 393
[395] Mathiharan,supra note 280
[396] Chaturvedi supra note 338
[397] Marshall v. Curry (1993)3 DLR 260
[398] Charan Lal Sahu v. Union of India, (AIR 1990 SC 1480)

without consent. The surgeon was held negligent for risking the ill effects of the patient under chloroform. Since this surgery was neither emergency nor in the best interest of the patient.[399]

At the same time, conducting an emergency surgery is a duty of the surgeon. A surgeon who failed to perform an emergency operation must prove with satisfactory evidence that the patient refused to undergo the operation, not only at the initial stage, but even after the patient was informed about the dangerous consequences of not undergoing the operation[400].

3.6 INFORMED CONSENT AND MEDICAL TREATMENT

A complex situation arises where a patient agrees to a proposed treatment or procedure, but claims that the information which led to the agreement was inadequate. Such a claim lies in negligence, not battery, and is based on the argument that, by failing to disclose certain information, the physician has breached a duty of care to the patient. This claim of lack of informed consent does not deny the existence of consent; such a claim challenges the adequacy of the information on which the patient's agreement was based[401].

Taber's Cyclopedic Medical Dictionary defines[402] informed consent as:

> Consent that is given by a person after receipt of the following information, the nature and purpose of the proposed procedure or treatment, the expected outcome and the likelihood of success and the risks. The alternatives to the procedure and supporting information regarding those alternatives and the effect of no treatment or procedure, including the effect on the prognosis and the material risks associated with no treatment. Also included are instructions concerning what should be done if the procedure turns out to be harmful or unsuccessful.

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[399] Ram Behari Lal v. JN Srivastava AIR 1985 MP 150, ACJ.
[400] Thomas v.Alisa AIR 1987 Ker 52
[401] Mack supra note
[402] K K Aggarwal, *Real Consent and not Informed Consent Applicable in India,* Indian Journal of Clinical Practice, Vol. 25, No. 4, September 2014.http://medind.nic.in/iaa/t14/i9/iaat14i9p392.pdf .Last visited on 29-08-2016 at 20.05

3.6.1 INFORMED CONSENT

Informed consent is an ongoing process rather than a mere signed form .It must involve willingness to listen and discuss patients problems concerned with the proposed treatment.[403] The following are essential ingredients of Informed Consent.

- Disclosure of Information

Disclosure of information includes the following: 1.Doctor should explain to his patient the exact nature of the disease or the ailment. 2. Patient must be clear about the need for the treatment and the nature of the procedure along with the expectation form the line of treatment recommended along with the likely chances of success. 3. Patient must be made aware of the alternative forms of treatment available with benefits and reasonably foreseeable adverse effects/risks and complications involved in both the proposed and alternative procedure. 4. The existence of a right to refuse all of them and the medico legal consequences of such refusal.5. The right to choose between proposed and alternative procedure must be exercisable and sufficient time must be given.

- Free and Voluntary Decision

Patient's consent must be voluntary and free from coercion, force and misrepresentation of facts. Consent to be legally valid must be intelligent, informed and voluntary and should be taken freely and exclusively by the patient. Nobody is authorized to give consent on behalf of the patient (with few exception discussed later)[404].

- Capacity to decide

This forms the most important aspect of informed consent. A competent person who is able to understand the nature of the act and logical consequences of the act should give consent. The person should be mature enough to understand,

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[403] Amit M. Patil & Vyankatesh T. Anchinmane, *Medicolegal Aspects of Consent in Clinical Practice*, Bombay Hospital Journal, Vol. 53 , No. 2 (2011). http://bhj.org.in/journal/2011-5302-april/download/203-208.pdf . Last visited on 29-08-2016 at 20.08

[404] Patil & Anchinmane supra note 404

analyze and assess the risks and benefits associated with such form of proposed treatment and accept the responsibility for the informed consent given to such treatment. A competent person must fulfill following criteria's[405], 1. He should be of sound disposing mind. 2. He should be legally competent to do so. 3. He should have proper reasoning for his decision. 4. He should be able to understand the implications of his consent. 5. He should be at least 12 years of age. 6. The informed consent will be legally valid when all the above mentioned components of informed consent are met.[406]

An informed consent in broad terms is an agreement by and between the patient or its legal guardian and the consulting doctor confirming that the patient or the guardian has been informed and understood about the disease or the condition, procedure planned, associated risk and complications, prognosis, alternative treatment available and other relevant information by the doctor and the patient agree upon them voluntarily, unbiased and under physical and mental state enabling him to give the consent[407] .The above description of an ideal consent clearly indicates three key requisite for this document to be valid. First, a consent should be voluntary, unbiased and given by the patient in free will. Secondly, it should be informed i.e. the patient or the subject prior to consent should be well informed in detail about the procedure, associated benefits, risk and complications and alternative treatment options available. The patient should be in capacity, physically and mentally to give the consent for the treatment or the procedure. Hence, consent can be considered as an agreement of mutual understanding for the services by the doctor and the patient as the consumer under Consumer Protection Act. [408] Informed consent is the continuous process of providing the patient or, in the case of a minor or incompetent adult, the custodial parent or legal guardian with relevant information by doctor regarding diagnosis and treatment needs so that an

[405] Patil & Anchinmane supra note 404
[406] *Id*
[407] Ravi Sharma , *Informed consent in clinical practice and research: ethical and legal Perspective*, International J. of Healthcare and Biomedical Research 144-151, Volume: 03, Issue: 01, October(2014) . http://ijhbr.com/pdf/October%202014%20144-151.pdf. Last visited on 29-08-2016 at 20.14
[408] *Id*

educated decision regarding consent for treatment can be made by the patient custodial parent/legal guardian.[409]

3.6.2 IMPLIED CONSENT

Quite often a physician undertakes treatment on the basis of consent, which is implied either by the words or behavior of the patient or by the circumstances under which treatment is given[410]. An implied consent is a consent which is not written, that is, its existence is not expressly asserted still it is legally effective. In implied consent, a patient indicates his consent by the behavior and conduct[411]. It implies consent to in a general sense. This is the most common form of consent seen in medical practice. But such type of consent is generally restricted to general and common procedure of medical examination. Beyond basic procedures it is necessary to take a full expressed informed consent.[412]

3.6.3 EXPRESSED CONSENT

In expressed consent, a patient specifically expresses his free consent to a physician to undertake diagnostic or therapeutic treatment. It is in distinct and explicit language. This may be expressed either verbally or in writing after having the patient informed about all the aspects of the diagnostic and therapeutic procedure. When the patient conforms verbally to a specific diagnostic or therapeutic procedure it is called as oral or verbal expressed consent and when he gives it in writing it is called as written expressed consent. Both the forms of expressed consent are accepted in the court of law as proof of consent. It is the written expressed consent, which has more value, as it is a permanent record[413]. It is a must in any examination beyond routine physical

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[409] Shahal et al., The Importance of Informed Consent in Medicine Scholars Journal of Applied Medical Sciences (SJAMS) Sch. J. App. Med. Sci., 455-463. 1(5) (2013).http://saspublisher.com/wp-content/uploads/2013/10/SJAMS15455-463.pdf . Last visited on 29-08-2016

[410] KENNETH G. EVANS,CONSENT: A GUIDE FOR CANADIAN PHYSICIANS.(4th ed. 2006)(booklet)

[411] Chaturvedi supra note 338

[412] Patil & Anchinmane supra note 404

[413] *Id*

examination. Expressed consent must conform to the doctrine of informed consent to be legally acceptable.[414]

For relatively minor examinations or therapeutic procedures, oral consent is employed. But this should preferably be obtained in the presence of a disinterested party. Oral consent, where properly witnessed, is as valid as written consent, but the latter has the advantage of easy proof and permanent form[415]. Consent may be confirmed and validated adequately by means of a suitable contemporaneous notation by the treating physician in the patient's record.[416] Express written consent should be obtained for all major diagnostic procedures, general anesthesia, for surgical operations, intimate examinations, and examination for determining age, potency, and virginity and in medico-legal cases. It should be obtained when the treatment is likely to be more than mildly painful, when it carries appreciable risk, or when it will result in diminishing of a bodily function [417]

3.7 MEDICAL CONSENT-LAW IN USA

The evolution of Informed Consent as a legal doctrine in America was based on the need to extend civil liability of medical practitioners as well as to promote patient's rights. This concept is explained in *Mohr v. Williams*, one of the earliest reported cases in this area.[*418*] In this decision which dates back to 1905, physician obtained consent to operate on one ear, but after the patient had been anesthetized, on a re-examination, he has decided to operate on the other ear. Patient sued for an unauthorized touching though operation was successful. The court made it clear, "If the operation was performed without patient's consent,

[414] Patil & Anchinmane supra note 404
[415] Chaturvedi supra note 338
[416] Chaturvedi supra note 338
[417] Dhingra C & Anand R , *Consent in Dental Practice: Patient's Right to Decide*. Oral Hyg Health ,Vol.2 Issue.2.(2014).`http://www.esciencecentral.org/journals/consent-in-dental-practice-patients-right-to-decide-2332-0702-2-129.pdf. Last visited on 29-08-2016 at 20.30
[418] 95 Minn. 261, 104 N.W. 12 (1905), See Martin R. Struder, *The Doctrine of Informed Consent: Protecting the Patient's Right to Make Informed Health Care Decisions*, 48 Mont. L.Rev. (1987).

and the circumstances were not such as to justify its performance without, it was wrongful; and, if it was wrongful, it was unlawful."[419]

However patient's right to self-determination was considered to be established in the historic decision of *Schloendorff v. Society of New York Hospital*[420] which came in 1914 in which Justice Cardozo made the emphatic statement:

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

This formed the fundamental principle of medical consent in US[421].There was a shift in the focus in later years from authority of doctor to the adequacy of disclosure of information.[422] The word 'informed consent' was first used in therapeutic practice in the landmark case of *Salgo v. Leland Stanford Jr. University Board of Trustees*[423] in 1957. In this case, Martin Salgo brought his physicians to court for their negligence and failure to warn him of the risk. Justice Bray ordered that physicians had an explicit duty to disclose certain forms of information and then to obtain the consent of their patient. The judgment discussed the question of sufficient information for obtaining consent, bringing focus to informed consent and the need to respect patient free choice. The doctrine of informed consent, as used now is thus attributed to this case.[424]The Judge has set it clear while holding, "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the

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[419] Martin R. Struder, *The Doctrine of Informed Consent: Protecting the Patient's Right to Make Informed Health Care Decisions*, 48 Mont. L.Rev. (1987).
[420] 211 N.Y. 125, 105 N.E. 92 (1914).Id
[421] Rathor et al.,*Informed Consent: A Socio-Legal Study*, Med J Malaysia Vol. 66 No. 5 December (2011). http://www.e-mjm.org/2011/v66n5/Informed_Consent.pdf. Last visited on 29-08-20156 at 21.38.05.See also R. Jason Richards, *How We Got Where We Are:A Look at Informed Consent in Colorado—Past, Present, and Future*, Northern Illinois University Law Review Vol. 26 October (2005).
[422] Struder supra note 418
[423] 154 Cal. App. 2d 560, 317 P.2d 170 (1957).
[424] Struder supra note 418

proposed treatment."[425] Later in *Cobbs v. Grant*[426]in 1972, it was observed, " When the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information."

By this time, eclipsing intervention without permission, omission of duty to disclose, came to the forefront in malpractice litigation. Cases earlier tried as battery eventually been evaluated as informed consent claims using negligence law[427]. It established disclosure as the duty of physician.

The reasonable physician standard was first articulated in 1960 by the Kansas Supreme Court in *Natanson v. Kline*.[428] In Natanson, the plaintiff had consented to radiation therapy after a mastectomy, and was injured by the radiation. She initiated a suit alleging that her physician did not disclose the risks of radiation therapy. The Court ruled that her consent was legally inadequate because of the absence of an adequate disclosure. [429] The reasonable physician standard presumes that, physician knows the best and what is reasonable to medical men is in the best interest of the patient. " [The physician] was obligated to make a reasonable disclosure to the [patient] of the nature and probable consequences of the suggested or recommended ... treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which were incident to, or possible, in the treatment he proposed to administer."[430]

The District of Columbia Circuit Court was the first to articulate a patient-oriented standard of disclosure in a 1972 case, *Canterbury v. Spence*.[431] In

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[425] Janet L. Dolgin, *The Legal Development of the Informed Consent Doctrine: Past and Present*, Legal Studies Research Paper Series Research Paper No. 10-24, HOFSTRA University School of Law. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1625306. Last visited on 29-08-2016 at 21.44

[426] Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

[427] Studdert et al., *Geographic Variation in Informed Consent Law: Two Standards for Disclosure of Treatment Risks*, Journal of Empirical Legal Studies Volume 4, Issue 1, 103-124, March 2007.Quoting JAY KATZ, *Silent World of Doctor and Patient* 65-69 (2002).

[428] 186 Kan. 393, 350 P.2d 1093 (1960).

[429] Struder supra note 418

[430] *Id*

[431] 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

Canterbury, a nineteen-year-old boy underwent surgery for a herniated disc following which, he was paralyzed. He took his physician to the court for the failure to disclose the risk of paralysis before performing the surgery. The court stated that the scope of the required disclosure must include risks that the patient views as material[432]. Doctrine of informed consent was defined in this judgment as the right to be informed of material risks inherent in, and alternatives to, proposed medical procedures.[433] It was held that "[t]rue consent to what happens to one's self is the informed exercise of a choice, and that entails the opportunity to evaluate knowledgeably the options available and the risks attendant upon each". The *Canterbury* court observed that:

> The physician's duty to disclose arose from three almost axiomatic considerations. First, every human being has a right to determine his or her own course of medical treatment. Second, real consent requires the informed exercise of choice, which in turn requires an opportunity to evaluate the options available and the risks associated with each. Third, the average patient has little understanding of medicine, and can only turn to a physician for advice.[434]

Hence respect for the plaintiff's right of self-determination demands a standard set by law, rather than one which physicians set for themselves.[435] *Canterbury Principle* established a new standard, requiring disclosure, tailor made for the special needs of each patient.[436]

In *Truman v. Thomas,*[437] a patient was advised to submit to a pap smear. The patient did not do so and was later diagnosed with cervical cancer. The physician was sued on the grounds that he failed to inform the patient about the risks associated with not having the Pap smear performed. The court did not accept the defense that the doctor cannot force patient to undergo a diagnostic procedure. It was held that the physician had a duty to disclose the risks associated with not having the Pap smear because that information was material

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[432] Douglas A. Grimm, *Informed Consent for All! No Exceptions*, New Mexico Law Review, Vol.37 Winter(2007).
[433] Rathor et al supra note 420
[434] *Id*
[435] *Id*
[436] Mathew Bennett, *A history of informed consent*, Psychotherapy Forum, Ventana centre for Psychotherapy(Last visited on 29-08-2016 at 21.50) http://www.ventanacenter.com/articlesbackground_007.
[437].Truman v. Thomas, 611 P.2d 902, 902 (Cal. 1980).

to her treatment. Thus, *Truman* increased the physician's responsibility by requiring disclosure of information even if they are normally considered to be common knowledge[438].And the principle got clarified in *Harnish v Children's Hospital Medical Center*, in 1982:

> We also recognize that there are limits to what society or an individual can reasonably expect of a physician in this regard. Medical matters are often complex. Recommendations of treatment frequently require the application of considerable medical knowledge gained through extensive training and experience… a physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to an intelligent decision by the patient whether to undergo a proposed procedure.[439]

Later judges, in various decisions, in number of different judicial forums had detailed discussion on the extent and dimension of this consent, practical difficulties in obtaining it, situations which will demand unilateral actions and doctors liability in case of patients refusal etc[440]. Courts in US follow two different standards while evaluating the scope of information those physicians must disclose for consent to be informed, one is the physician-oriented and the other is patient-oriented. The physician-oriented standard adopts the reasonable physician's viewpoint of what information should be disclosed, while the patient-oriented standard adopts the patient's viewpoint. The patient-oriented viewpoint has gained acceptance, but the traditional, physician-oriented viewpoint is still the law in many states.[441]Currently, the states are almost evenly split between two types of standards for informed consent – the physician-based standard, effective in 25 states, and the patient-based standard, effective in 23 states and the District of Columbia[442]. However an empirical

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[438] supra Note 135

[439] Harnish v. Children's Hospital Medical Center 387 Mass. 152; 439 N.E.2d 240, 155, *See* Murray Earle, *The Future Of Informed Consent In British Common Law*, European Journal of Health Law 6: 235-248(1999).

[440] Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, Michigan Journal of Gender and Law ,Vol.19 Issue 1,19 Mich. J.Gender & L. 1 (2012).See also Jaime Staples King and Benjamin Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, American Journal of Law & Medicine, 32 (2006).

[441] Douglas A. Grimm supra note 431

[442] Jaime Staples King & Benjamin Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision Making,* American Journal of Law & Medicine 429-501, 32 (2006).

study published in Journal of Empirical Legal Studies, Stoddert et al. (2007), shows significant difference in impact as the states with patients' standard are having more decisions favoring plaintiff as compared to those with professional standards[443]

3.8 THE REAL CONSENT-LAW IN UK

The earliest record of English law with respect to lack of consent can be traced back to the case of *Slater v. Baker and Stapleton* in 1767. In this case, physicians removed the bandages from a partially healed leg fracture against patient's protests. Slater sued doctors for undertaking unwanted treatment. The explicit objections of the patient to the procedure countered any presumption as to the implied consent and doctors were held liable for battery.[444]

The concept of adequate disclosure for obtaining consent as a standard of medical care has been formulated by the court in *Bolam v Frien Hospital Management Committee*[445] in 1957. In this case, the patient sued the hospital and its doctors for negligence in performing electroconvulsive therapy which resulted in an injury. The patient claimed that he was not informed clearly about the possible dangers before taking his consent. Judge MCNAIR stated:

> …(a doctor) is not guilty of negligence, if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . .a man is not negligent, if he is acting in accordance with such practice merely because there is a body of opinion who would take a contrary view. At the same time that does not mean that a medical man can obstinately and pigheadedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion . . ."[446]

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[443] Studdert et al.supra note 426

[444] Emma C. Bullock, *Informed Consent And Justified Hard Paternalism*, thesis submitted to the University of Birmingham for the degree of DOCTOR OF PHILOSOPHY, April (2012). http://etheses.bham.ac.uk/3400/2/Bullock_12_PhD.pdf. Last visited on 29-08-2016 at 22.04

[445] Bolam v. Friern Hosp. Management Comm., [1957] I W.L.R. 582. See Frances H. Miller , *Informed Consent For The Man On The Clapham Omnibus: An English Cure For "The American Disease"?* Western New England Law Review, 9 W. New Eng. L. Rev. 169 (1987).

[446] *Bolam* supra note 445

Similar view was expressed in a Scottish case, *Hunter v. Hanley*[447] where, Lord President CLYDE said

> In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.

The case further laid down the requirements to be established by a patient to make the physician liable for negligence.

> To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.

Bolam test based on *Bolam and Hunter*[448] decisions establishes negligence relative to the medical profession. It established disclosure of information as a pre-requisite for obtaining consent. At the same time asserted that 'the doctor knows better' and thereby his discretion plays a vital role in deciding 'what to disclose?' *Bolam* test is therefore, finding an answer for, 'what can the reasonable doctor be expected to have disclosed to this patient?' and never 'what would the reasonable patient expect to be told?' [449]

Later in 1984, through the majority view in *Sidaway* v *Bethlem Royal Hospital Governors,* the House of Lords affirmed that informed consent is 'contrary to English law, and the *Bolam* test is appropriate to test the standard of information given to a patient'. Lord SCARMAN in his dissenting view expressed that a doctor's duty to supply information on risks and alternatives derives from the

[447]Hunter v Hanley 1955 SC 200. Quoted in Samira Kohli v. Prabha Manchanda and Ors. I (2008) CPJ 56 (SC)
[448] Bolam v Frien Hospital Management Committee[1957] I W.L.R. 582 and Hunter v. Hanley. 1955 SC 200
[449] Murray Earle, *The Future Of Informed Consent In British Common Law*, European Journal of Health Law 235-248 6 (1999).

patient's rights. He suggested a different point of view on disclosure of information to the patient.[450]. According to Lord Scarman 'the *Bolam* doctrine imposed the duty of care but the standard of care was left for medical judgment'[451] Therefore in such situation, discretion is subject to the test of reasonability only by one's own fellowmen, which tends to be potentially biased. Though Lord SCARMAN's view was not qualified to be binding, later years saw much positive critique for this dissenting opinion.

Maynard v. West Midland Regional Health Authority[452] was a case of negligent treatment or diagnosis. In this case, the House of Lords held[453]that

"…the true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether she has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care."

Lord SCARMAN stated :

> A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.

English courts have accepted the importance of medical consent. At the same time, legal actions were limited to situations where absence of any consent is clearly alleged. The patient's consent is expected to be 'real', in the sense that,"…the patient [has been] in-formed in broad terms of the nature of the

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[450] (1985) 1 All ER 643 HL, (1984) 2 WLR 778. *id*

[451] Editorial- *Adequately informed consent-Journal of medical ethics*, 1985, 11, 115-116, September 2, 2015 group.bmj.com,Available at: http://jme.bmj.com/content/11/3/115.full.pdf. Last accessed on 10/11/15 at 3.39

[452].134. Maynard, (1984] 1 W.L.R. 634. See,Andrew Grubb, *A Survey of Medical Malpractice Law in England: Crisis? What Crisis?*, Journal of Contemporary Health Law & Policy, 1 J. Contemp. Health L. & Pol'y 75 (1985).http://scholarship.law.edu/jchlp/vol1/iss1/7. Last accessed 0n 10/11/15 at 3.41 p.m

[453] *Id*

procedure". In other words, patient must be given "enough time and an environment to enable him **...** carefully to consider his**....** position.[454]

Chester v Afshar[455] in 2004 provided a significant development of law in this field. Till that time, the majority of legal debate has revolved around the standard of care and the amount of information patients are entitled receive. Quite differently, here, the issue was of causation[456]. The patient was suffering from back pain for a long time. As concluded from an MRI scan, there was a disc protrusion into her spinal column and was advised surgery. The neurosurgeon was under a duty to warn the patient that there is a 1-2% risk that even if performed without negligence, the surgery may worsen rather than improve her condition. The operation was performed and it worsened her condition. The plaintiff argued that, if she had been given information about the risk, she would have taken time to decide or look for alternatives. The trial judge held the surgeon not been negligent in performing the operation. But his failure to warn her of the risk was found to be a breach of duty. Being dismissed by the Court of Appeal, defendant approached the House of Lords.[457] The surgeon argued that, even if performed at a later stage, the surgery wouldn't have been successful. Dismissing the appeal Lord HOPE expressed:

> To leave the patient who would find the decision difficult without a remedy, as the normal approach to causation would indicate, would render the duty useless in the cases where it may be needed most. This would discriminate against those who cannot honestly say that they would have declined the operation once and for all if they had been warned. I would find that result unacceptable. The function of the law is to enable rights to be vindicated and to provide remedies when duties have been

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[454] Chatterton v. Gerson, [1981] 1 Q.B. 432, 443, Ferguson v. Hamilton Civic Hospitals 144 D.L.R. 3d 214, 248 (1983) (Krever, J.).quoted by Andrew Grubb, A Survey of Medical Malpractice Law in England: Crisis? What Crisis? Journal of Contemporary Health Law & Policy, 1 J. Contemp. Health L. & Pol'y 75 (1985). Available at: http://scholarship.law.edu/jchlp/vol1/iss1/7. Last accessed 10/12/15 at 4.42 .

[455] Chester v Afshar [2004] 3 WLR 927 House of Lords http://www.e-lawresources.co.uk/Chester-v-Afshar.php. Last accessed on 10/12/15 at 4.35 p.m

[456] Rob Heywood, *Informed Consent through The Back Door? Case Note: Chester v Afshar [2004] 4 All ER 587*. http://www.exodontia.info/files/Informed_Consent_Through_The_Back_Door._Case_Note_-_Chester_v_Afshar_2004._Rob_Heywood.pdf. Last accessed on 10/12/15 at 4.34 p.m

[457] Rob Heywood, supra note 456

> breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfill the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.[458]

The House of Lords accepted the concept that injury is within the scope of the doctor's duty and omission to provide information can be a cause for injury. This case has further advanced law and established that a doctor has a duty to inform possible complications of any medical procedure.[459]

Montgomery v. Lanarkshire Health Board [460] is the most recent and epoch making judgment in this area ,since it established that informed consent is now part of English law .By this judgment the age old *Bolam* Test is out of use and the *Sidaway* judgment is overruled.

Facts of the case

In 1999 Mrs. Montgomery who is a diabetes patient was expecting her first baby. It is a possibility that women suffering from diabetes will have babies that are larger than normal. There can be a particular concentration of weight on the baby's shoulders known as shoulder dystocia. Mrs. Montgomery's was regarded as a high risk pregnancy requiring intensive monitoring[461]. Therefore she has attended the combined obstetric and diabetic clinic at Bellshill Maternity Hospital, under the care of Dr McLellan, throughout her pregnancy. Mrs. Montgomery was told that she was having a larger than usual baby. But she was not told about the chances of difficulties during labor. Dr McLellan

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[458] Rob Heywood, supra note 456
[459] Denis A Cusack, *The Standard of Care In Medical Practice And Disclosure Of Treatment Risk To Patients - An International Perspective*, Medical Defense Malasya.Available at: Http://Mdm.Org.My/Downloads/Cusack1.Pdf. Last accessed on 10/12/15 at 4.36 p.m
[460] [2015] UKSC 11, https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf. Last accessed on 10/12/15 at 16.37
[461] Cusack supra note 460

knowing that this is a high risk case did not want to discuss the potential risks of shoulder dystocia with her patient. According to her, if the condition is mentioned, most women will prefer to have a caesarean section. The labor was induced and after several hours of pain and suffering, it became arrested. Child was pulled out using external devices. During this procedure for 12 minutes, child was deprived of oxygen due to occlusion of the umbilical cord. After birth, the child was diagnosed as suffering from cerebral palsy and brachial plexus affecting all four limbs. Patient sued against the physician claiming that, if informed about the risk, she would have opted for an elective caesarean section which would have saved her son from this injury[462].

Two contentions were invoked before the Court of Session. First was about failure to provide adequate information about the risk of shoulder dystocia in vaginal birth. The second was that the doctor was negligent in not electing to do caesarian section in spite of the abnormalities and difficulties in performing a vaginal delivery. The Lower Court, following the *Sidaway* judgment, held that whether a doctor's omission to warn a patient of inherent risks of proposed treatment constituted a breach of the duty of care was normally to be determined by the application of the test *Bolam* test. Therefore it is subjective, depending on whether the omission was accepted as proper by a responsible body of medical men.

Lord KERR and Lord REED in this decision expressed that, while holding so, the Court of Session did not follow the approach followed in a more recent decision in *Jones v North West Strategic Health Authority*[463]which had similar facts. In that decision the risk of shoulder dystocia was in itself held to be sufficiently serious for the expectant mother to be entitled to be informed. The Court observed that in England and Wales, although *Sideway's* case remains binding, lower courts have tacitly ceased to apply the *Bolam* test in relation to disclosure of information. Instead they have effectively adopted the view of Lord

[462] *Id*
[463] [2010] EWHC 178 (QB), [2010] Med LR 90

SCARMAN[464].The case of *Pearce v United Bristol Healthcare NHS Trust*[465] is quoted as an example. This particular case concerned an expectant mother whose baby had gone over term. Physician advised her to wait and have a normal delivery, rather than a caesarean section at an earlier date. The baby happened to die *in utero*. It was held that:

> In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law, as indicated in the cases to which I have just referred, 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 a doctor to inform the patient of that 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.[466]

Analyzing legal position in some other common law jurisdictions, mainly in Canada and Australia, the Court held that:

> Since Sidaway... it has become increasingly clear that the paradigm of the doctor-patient relationship implicit in the speeches in that case has ceased to reflect the reality and complexity of the way in which healthcare services are provided, or the way in which the providers and recipients of such services view their relationship. One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, as consumers exercising choices..... The treatment.....is now understood to depend not only upon... clinical judgment, but upon bureaucratic decisions as to such matters as resource allocation, cost-containment and hospital administration: decisions which are taken by non-medical professionals…In addition to these developments in society and in medical practice, there have also been developments in the law. Under the stimulus of the Human Rights Act 1998, the courts have become increasingly conscious of the extent to which the common law reflects fundamental values. As Lord Scarman pointed out in Sideway's case, these include the value of self-determination.....The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in Sidaway by Lord Scarman, and by Lord Woolf MR in Pearce, subject to the refinement made by the High Court of Australia in Rogers v Whitaker..... An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a

[464] supra note 460
[465] [1999] PIQR P 53
[466] supra note 460

> duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

The significance of Montgomery decision in legal history is that it has established the existence of informed consent doctrine in UK.Law was settled that it is 'informed consent' not 'real consent' which the doctors need to obtain before medical intervention.

3.9 COMMON LAW JURISDICTIONS

The influence of *Canterbury principle* is present in other Common law jurisdictions too. In 1980, the Supreme Court of Canada rendered two landmark decisions regarding the duty of a physician to make disclosure to the patient.

In *Hopp v. Lepp*[467], the question was whether a patient who suffered permanent damage after the performance of a surgery had given informed consent to the procedure. After suggesting that the patient had a right to decide what, if anything should be done with his body, Laskin C.J. went on to hold that there was a duty of disclosure, that is, the surgeon or physician was bound by a duty to provide information to his or her patient.

> In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.

The Supreme Court of Canada again had reason to address the issue of informed consent, among other issues, in the leading case of *Reibl v. Hughes*[468]. In this

[467] [1980] 2 S.C.R. 192 .*Id*
[468] (1980) 114 DLR (3d) 1

judgment,Hopp v. Lepp was considered in the context of the plaintiff's claim that he had not given informed consent to an endarterectomy procedure that had left him a hemiplegic[469].

Broadly speaking, it was the *Reibl j*udgment that introduced the doctrine of informed consent into Canadian law. Building on his reasons in *Hopp v. Lepp*, LASKIN C.J., confirmed that the relationship between a doctor and a patient undoubtedly gives rise to a duty of the doctor to disclose material risks associated with a procedure, without having to be questioned by the patient. Thus, the traditional standard of disclosure – that is, what a reasonable physician would disclose – was replaced with the standard of what a reasonable patient would want to know.

While the judgment of LASKIN C.J. also restricted the tort of battery to those cases where surgery or treatment was performed or given without any consent or where it went beyond the consent given.The important conclusion was relating to proper test for causation. It was held that the subjective test for causation – that is, what a particular patient would have done if properly informed – should be replaced with a modified objective test that will determine what a reasonable person in the plaintiff's position would have done if ,properly informed[470].

> In saying that the test is based on the decision that a reasonable person in the patient's position would have made, I should make it clear that the patient's particular concerns must also be reasonably based; otherwise, there would be more subjectivity than would be warranted under an objective test. Thus, for example, fears which are not related to the material risks which should have been but were not disclosed would not be causative factors. However, economic considerations could reasonably go to causation where, for example, the loss of an eye as a result of non-disclosure of a material risk brings about the loss of a job for which good eyesight is required. In short, although account must be taken of a patient's particular position, a position which will vary with the patient, it must be objectively assessed in terms of reasonableness. [471]

[469] Cusack supra note 459
[470] Cusack supra note 459
[471] *Id*

In Canada the decision of *Reibl v Hughes* settled the law that the doctor has to disclose 'material' information and what is 'material' is not for the doctor to decide.[472] Prior to this decision, there was some doubt as to whether the doctor had the duty to ensure that patient was understood. However, Laskin C.J. made it quite clear in that case that it was the responsibility of the doctor to make sure that he has understood. Specifically, when the patient had some difficulty with the language spoken by the doctor, he has to take all measures to ensure the proper disclosure of information. The burden is placed on the doctor to show that the patient comprehended the explanation and instructions given. [473] Providing patients with relevant information is not the only challenging component of the informed consent process. Canadian law clearly imposes some responsibility on physicians to ensure patients understand what they have been told.[474]

To determine if the standard of care owed by the medical practitioner includes an obligation to disclose the information in issue, a court relies on expert evidence as to the general practice of reasonable or prudent doctors regarding disclosure. However, the South Australian Supreme Court has frequently stated that such testimony is not conclusive. [475]If the court finds that the accepted medical practice is below the appropriate legal standard, then a doctor's actions could be held to be a breach of legal duty to inform and hence actionable, even though the physician's conduct conformed to an accepted medical practice Similarly The High Court of Australia in *Rogers v Whitaker* [476]imposed an obligation upon practitioners to disclose to patients all material risks inherent in undergoing or forgoing surgery or other interventions. An inherent risk of a procedure is one which 'cannot be avoided by' the practitioner's 'exercise of reasonable care and skill'. The majority observed that whether, a risk is to be termed as material in the circumstances of the particular case is not the doctor to decide. But, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it is more important. If warned of

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[472] *Id*
[473] Ciarlariello v Schacter 6 [1993] 2 SCR 119, 100 DLR (4th) 609.
[474] Burningham et al., McGill Journal of Law and Health 123-128,Vol. 7 No.1(2013).
[475] D v S (1981) 93 LSJS 405, F v R (1983) 33 SASR 189,
[476] Rogers v Whitaker (1993) 4 Med LR 79, (1992) ALJR 47, (1992) 109 ALR 625,*Id*

the risk, would the patient likely to attach significance to it is the significant aspect of disclosure.[477] .The Court analyzed Bolam test and rejected that principle. The Court said 'what the particular plaintiff would have wanted to have been told' is critical while obtaining consent[478].

> There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to the patient . . .because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession.[479]

This tendency is visible in Malaysian Courts as well. In Hong *Chuan Lay v Eddie Soo Fook Mun*[480] the court held that it was for the court, and not medical men, to judge the adequacy of information disclosed. In *Foo FioNa v. Dr. Soo FookMun*[481], the Federal Court, the final court of appeal in Malaysia said,

> We are of the opinion that the Bolam test has no relevance to the duty and standard of care of a medical practitioner in providing advice to a patient on the inherent and material risks of the proposed treatment." The Federal Court in its conclusions stated that "we are of the view that the Rogers v Whitaker test would be more appropriate and a viable test of this millennium than the Bolam tes[482].

3.10 MEDICAL CONSENT IN INDIA

On medical consent, the Supreme Court of India said:

> 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 (informed consent) 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

[477] Tracey Carver and Malcolm K Smith, Medical Negligence, Causation And Liability For Non-Disclosure Of Risk: A Post-Wallace Framework and Critique,972-973 Volume 37(3) UNSWLaw Journal(2014).
[478] Murray Earle, supra note 448
[479] *Id*
[480] Hong Chuan Lay v Dr. Eddie Soo Fook Mun 3 AMR. 2301; 1998
[481] Foo Fio Na v Dr Soo Fook Mun and Anor. 1, 593 MLJ. 2007
[482] Rathor et al supra note 420

> and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment. [483]

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[484].

In *Samira Kohli's case,* the Supreme Court of India states that consent in the context of a doctor–patient relationship is defined as grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure. Consent can be implied in some circumstances from the action of the patient. This order gives the principles of consent with regard to medical treatment and therapeutic investigations and not for medical research/clinical trials as follows:-

- A doctor has to seek and secure the consent of the patient before commencing a'treatment'.The consent so obtained should be real and valid; the consent should be voluntary; and the consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that she/he knows what she/he is consenting to.
- A balance should be maintained 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.
- Consent given only for a diagnostic procedure cannot be considered as consent for treatment. Consent given for a specific treatment procedure is not valid for some other treatment or procedure.
- There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a

[483] Samira Kohli v. Prabha Manchanda and Ors. I (2008) CPJ 56 (SC).
[484] *Sameera Kohli Id*

particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

- 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 that 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.

The Supreme Court of India established that the standard for obtaining consent by the doctor before medical intervention is that of a reasonable doctor followed by House of Lords in *Bolam v Frien Hospital Management Committee* and not the reasonable patient standard which is set up in *Canterbury v. Spence*.

Facts of the case

Samira Kohli, an unmarried woman aged 44 years, visited Dr. Prabha Manchanda in the year 1995, complaining of prolonged menstrual bleeding. The respondent examined and advised her to come for a laparoscopy test under general anesthesia, for making an affirmative diagnosis. The patient in this case went to the respondent's clinic with her mother. The consent form for surgery described the procedure to be undergone as "diagnostic and operative laparoscopy". Patient was put under general anesthesia and subjected to a laparoscopic examination. When she was still unconscious, a junior doctor, who was assisting Dr.Prabha Manchanda, came out of the operation theatre and took the consent of appellant's mother for an a abdominal hysterectomy (removal of uterus) and bilateral salpingo-oopherectomy (removal of ovaries and fallopian tubes) which was immediately performed. Later, Sameera Kohli lodged a complaint against the physician for unauthorized removal of her reproductive organs.

While analyzing this case law, it is pertinent to note its comparative significance with the judgment delivered by House of Lords in *Sidaway*[485]. Both were

[485] Sidaway v Bethlem Royal Hospital Governors (1985) 1 All ER 643 HL

concerning the existence and extent of informed consent and were delivered by the apex courts of the corresponding countries. But their resemblance goes much more deep.

As far as *Sidaway* is concerned, it has a historical importance. The North American doctrine of informed consent was discussed in England for the first time in this case. Though it was a dissenting opinion, the view expressed by Lord Scarman made a profound impact in English legal and medical academia. In *Sidaway case,* the plaintiff suffered persistent neck and shoulder pain due to an accident. The defendant surgeon, Mr. Falconer[486], performed a spinal disc operation on her which ultimately relieved her discomfort for several years. Later Mrs. Sidaway was admitted to the hospital for evaluation and a myelogram revealed another pressure on a nerve root and was operated. As a result of the surgery, patient's spinal cord was damaged making her partially paralyzed. She complained that the surgeon has failed to exercise his duty to provide information prior to the operation for obtaining the consent.

The House of Lords, by majority, adopted the Bolam test, as the measure of doctor's duty to disclose information about the potential consequences and risks of proposed medical treatment.

In the dissenting view Lord SCARMAN observed that any kind of medical intervention is against the patient's autonomy to his body and therefore must be with consent. The patient has the right to take decision about his own body:

> If, therefore, the failure to warn a patient of the risks inherent in the operation which is recommended does constitute a failure to respect the patient's right to make his own decision, I can see no reason in principle why, if the risk materialises and injury or damage is caused, the law should not recognise and enforce a right in the patient to compensation by way of damages.[487]

Lord SCARMAN brought attention to another important aspect involved in the actual process of consent. The reasons which the doctor considered important for decision making need not be the same as that of the patient. Patients may

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[486] Surgeons are addressed as Mr. in England, whereas all other M.D.s are called Dr. See Frances H. Miller, *Informed Consent For The Man On The Clapham Omnibus: An English Cure For "The American Disease"?*Western New England Law Review, 9 W. New Eng. L. Rev. 169 (1987).

[487] supra note 460

have an entirely different set of grounds which he considers significant for his decision. They need not necessarily be 'medical'. Therefore it is indispensable that the patient gets information on all material facts affecting his decision making. He concluded that information is material if a patient considers it to be important. The Doctor has a duty to provide information about those material risks which a 'prudent patient' in the situation of the patient would have considered significant. Any omission on the part of the doctor to provide such information can be considered as negligence.

However, the majority viewed that the test of liability in respect of a doctor's duty to warn his patient of risks is "in accordance with the practice accepted at the time as proper by a responsible body of medical opinion." The House of Lords upheld the decision of the Court of Appeal that the doctrine of informed consent based on full disclosure of all the facts to the patient, is not the appropriate test of liability for negligence, under English law[488].

Lord BRIDGE stated :

> I recognize the logical force of the Canterbury doctrine, proceeding from the premise that the patient's right to make his own decision must at all costs be safeguarded against the kind of medical paternalism which assumes that 'doctor knows best'. But, with all respect, I regard the doctrine as quite impractical in application….

RAVEENDRAN, J. in Samira Kohli,[489] makes a thorough analysis of the North American doctrine of Informed Consent. The Canterbury judgment is quoted at length[490]:

> True consent to what happens to one's self is the informed exercise of a choice… To the physician, whose training enables a self- satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.

However the Court finds that this principle was not accepted in England as Bolam Test was always the authority. An analysis of both the opinions expressed in Sidaway judgment is made to conclude that the high standards of

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[488] Samira Kohli v. Prabha Manchanda and Ors. I (2008) CPJ 56 (SC

[489] *Id*

[490] Canterbury v. Spence 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

Canterbury were not found practical even in England. Referring to the judgments delivered by the Indian Supreme Court in *Achutrao Haribhau Khodwa v. State of Maharashtra*[491] and *Vinita Ashok v. Lakshmi Hospital*[492], the Court reaches to similar findings about India.

At the same time, the Hon'ble Justice makes due note of the radical expression in *Vinita Ashok's* case, which goes beyond the standard set by Bolam.:

> … doctor will be liable for negligence in respect of diagnosis and treatment in spite of a body of professional opinion approving his conduct where it has not been established to the court's satisfaction that such opinion relied on is reasonable or responsible. If it can be demonstrated that the professional opinion is not capable of withstanding the logical analysis, the court would be entitled to hold that the body of opinion is not reasonable or responsible.

The judgment further widens its dimension to the socio-political aspects of health care in India

> …. majority of citizens requiring medical care and treatment fall below the poverty line. Most of them are illiterate or semi-literate. They cannot comprehend medical terms, concepts, and treatment procedures. They cannot understand the functions of various organs or the effect of removal of such organs. They do not have access to effective but costly diagnostic procedures. Poor patients lying in the corridors of hospitals after admission for want of beds or patients waiting for days on the roadside for an admission or a mere examination, is a common sight. For them, any treatment with reference to rough and ready diagnosis based on their outward symptoms and doctor's experience or intuition is acceptable and welcome so long as it is free or cheap; and whatever the doctor decides as being in their interest, is usually unquestioningly accepted. They are a passive, ignorant and uninvolved in treatment procedures. The poor and needy face a hostile medical environment - inadequacy in the number of hospitals and beds, non-availability of adequate treatment facilities, utter lack of qualitative treatment, corruption, callousness and apathy…..

The Court finds doctors in public sector as overworked, understaffed, with little or no facilities and limited choice of medicines and treatment procedures.

Some stark observations about the Private sector,

> ….. There is a general perception among the middle class public that these private hospitals and doctors prescribe avoidable costly diagnostic procedures and medicines, and subject them to unwanted surgical procedures, for financial gain. The public feel that many doctors who

[491] 1996 (2) SCC 634,
[492] 2001 (8) SCC 731

> have spent a crore or more for becoming a specialist, or nursing homes which have invested several crores on diagnostic and infrastructure facilities, would necessarily operate with a purely commercial and not service motive; that such doctors and hospitals would advise extensive costly treatment procedures and surgeries, where conservative or simple treatment may meet the need; and that what used to be a noble service oriented profession is slowly but steadily converting into a purely business. Unfortunately, the noble tribe is dwindling. Every Doctor wants to be a specialist. The proliferation of specialists and super specialists, have exhausted many a patient both financially and physically, by having to move from doctor to doctor, in search of the appropriate specialist.

The adverse impact of legal measures against private players in health sector are identified.

> …. More and more private doctors and hospitals have, of necessity, started playing it safe, by subjecting or requiring the patients to undergo various costly diagnostic procedures and tests to avoid any allegations of negligence… more and more doctors particularly surgeons in private practice are forced to cover themselves by taking out insurance, the cost of which is also ultimately passed on to the patient, by way of a higher fee…

The Judgment, takes due care in establishing a clear standard on medical consent in India. And the attempts to balance the interests of either side are remarkable. The statement, "adequate information to be furnished by the doctor……to enable the patient to make a balanced judgment", solely qualifies the celebrated standard of "informed consent" expressed by *Canterbury* in 1972. According to *Canterbury*, "To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential….. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care."

But the Supreme Court at this point withdraws from making a bold change in the law and concludes in this way:

> 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 is affirmed that, even though it may appear to be not in favor of recent trends, we must follow Bolam test. The Court makes a mention that the principle is being challenged in its birth place itself. "Lord Scarman's minority view in *Sidaway* favoring *Canterbury*… may ultimately become the law in England... Inevitably, a day may come when we may have to move towards Canterbury. But not for the present."[493]

When is that time which will be apt for us to move towards Canterbury? "… if medical practitioners and private hospitals become more and more commercialized, and if there is a corresponding increase in the awareness of patient's rights among the public..".

The standard set by the Supreme Court is followed in later decisions by various courts.In *Ram Gopal Varshney's* case[494],the National Commission allowed the complaint for the reason that there was no informed consent obtained from the patient and though there was no deficiency in service on the part of the treating doctor insofar as the treatment administered to the patient is concerned. In *Dhanwanti Kaurs* case[495] surgery for removal of stones in gall bladder was performed upon the patient by adopting laparoscopic procedure and the doctor without obtaining the consent of the complainant's husband opted for open cholecystectomy. The National Commission held that there was no informed consent from the complainant or her husband for conducting open cholecystectomy and the opposite party failed to exercise requisite care and attention during postoperative stage.In *Baidya Nath Chakraborty(Dr) v.Chandi Bhattacharjee* [496],it was held that consent of the patient has to be on the basis of 'adequate information' concerning the nature of the treatment procedure,so that he knows what he is consenting to. 'Adequate information' should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment or not, and it would include disclosure of information regarding alternatives, if any available. In *G.Rajendra vs. City Hospital and others* [497],the National commission held that, consent taken prior, even to the

[493] *Vinita Ashok Id*
[494] Ram Gopal Varshey v. Lasor Sight India pvt ltd and another.(2009)CPJ 23(NC)
[495] Dhanwanti Kaur v. S.K.Jhujhunwala(Sr) and another 2010(6) ALD 19(NC)
[496] II(2014)CPJ 601 (NC)
[497] III(2014) CPJ 598 (NC)

decision on choice of procedure can, by no stretch of imagination be 'informed consent'.

In *Convenient Hospitals v. Sankar Lal* [498], it was held by the National Commission that consent obtained was defective for the reason that the alternatives to angioplasty were not explained to the patient.. In *Smt. Saroj Chandhoke v. Sir Ganga Ram Hospital* [499], after a Hysterectomy, the complainant lost her ovaries and left kidney. She was required to undergo other operations for control of fecal discharge from vagina and prolonged stay in the hospital for months. It was alleged, there was no emergent requirement for trying to operate via vaginal route and no consent was obtained for removal of ovaries in advance planned surgery. The patient was prepared for Hysterectomy and had given written consent for it.No consent was obtained or no information was given to the patient that her ovaries would be removed. It was held that:

> …it cannot be said that because a surgeon is expert in the field he/she can carry out the surgery of his choice. If he does so, he/she does it at his risk in case of mishap….No doubt, in case of emergency there can be deviation in mode of surgery, but not in a planned surgery where express consent for a particular mode is taken from the patient, particularly, when there is no emergency. ... before performing surgery, properly informed written consent is must. No doubt, while operating, to control adverse situation or to save the life of the patient or for benefit of the patient, other procedure could be followed or other part of the body could be operated… it is to be seen that superiority of the doctor is not abused in any manner"

In *K. A. Bhandula & Another v. Indraprastha Apollo Hospital & Others* [500],the National Commission summarised principles relating to consent as follows:

(i) 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

[498] I(2015)CPJ 134 (NC)
[499] III (2007) CPJ 189 NC
[500] [III (2009) CPJ 164 (NC)]

should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what he is consenting to.

(ii) 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 balance 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.

3.11 DOCTOR –PATIENT RELATIONSHIP: CURRENT SCENARIO

As per the available data, there is an increased use of technology in diagnostics and treatment of diseases in India, coupled with rising knowledge and expectations of the population regarding therapeutic measures, causing cost of health care becoming exorbitant. This increase has led to inequity in access to healthcare services[501].Another alarming fact is that, the share of centre in total public expenditure on health is declining steadily over the years. In India public spending on health, as a percentage of GDP, is one of the lowest among South-East Asian countries and the lowest among Brazil, Russia, India and China (BRIC nations)[502]. In *Vincent Panikulangara vs. Union of India*[503]**,** the Supreme Court of India observed: “Maintenance and improvement of public health have

[501] National Health Profile-2015. ww.cbhidghs.nic.in/writereaddata/mainlinkFile/NHP-2015.pdf.Last visited on 6-10-2016 at 8.29
[502] National Health Profile-2015. ww.cbhidghs.nic.in/writereaddata/mainlinkFile/NHP-2015.pdf.Last visited on 6-10-2016 at 8.29:
[503] AIR 1987 SC 990

to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends the building of the society of which the Constitution makers envisaged."

Doctors and patients, even if they come from the same social and cultural background, view ill health in different ways.[504] In India they are in fact from two different worlds. Specialization and super-specialization is producing a generation of doctors whose focus is miniscule.The objective approach towards general medicine and treatment is disappearing.[505]The healthcare system in India is one of the most privatized in the world. The latest in technological medicine is available to those who can afford to pay a higher price; but the vast majority, has little or no access to healthcare.[506]

In a study conducted on doctor patient relationship, it was reported that socio cultural factors influence concordance of patients with doctors. Higher economic status is related to better concordance[507]. Urban patients enjoyed better compatibility than their rural counterparts. People who did not share a common mother tongue with the doctors were less benefitted by interaction. It was clearly observed that better trust in physician was related to better patient enablement. And the major challenges to the doctor patient concordance is decreasing generalization, cultural & educational barriers and increasing commercialization of medical practice. The doctor patient relationship is the keystone of healthcare and essentials of a good doctor patient relationship are clear communication, mutual respect, confidentiality, professional honesty and trust. Doctor and the patient contribute to it. But there is a higher responsibility on the part of the doctor to ensure its presence, being professional whose services are sought and paid for.[508]

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[504] Amitav Banerjee& Debmitra Sanyal, *Dynamics of doctor–patient relationship: A cross-sectional study on concordance, trust, and patient enablement*, Journal of Family and Community Medicine12-19, Vol 19 Issue 1 (April 2012).quoting HELMAN C.G (ed.). DOCTOR PATIENT INTERACTIONS IN CULTURE, HEALTH AND ILLNESS. (3rd ed. 1994)

[505] *Id*

[506] David Berger,*Corruption Ruins The Doctor-Patient Relationship In India*, , BMJ 348:G3169 Doi:10.1136/Bmj.G3169 (8 May 2014).(Last visited on15-10-2015 at 7.25 a.m).ww.bmj.com/content/348/bmj.g3169 .(Personal View)

[507] Banerjee,& Sanyal supra note 504

[508] Dhingra & Anand ,supra note 417

In 2008, the Supreme Court observed that the 'noble tribe' is dwindling. Since then it has taken a faster pace and the healthcare sector is dangerously commercialized today.

The opinion expressed by the Punjab & Haryana High Court in *Daljit Singh's* case [509]reflects the state of affairs more clearly:

> Medical profession is one of the oldest professions of the world and is the most humanitarian one. There can be no better service than to serve the suffering, wounded and the sick….Unfortunately, now a days with the upcoming of corporate culture, medical profession which was highly respected is indicating decline of standards ….

The ordinary citizen approaching judiciary in medical negligence cases is ill-informed, less-empowered and therefore ill-equipped to fight the legal battle. The very delicate-physical, mental and financial-situation in which he is in, prevents him from understanding the negligence, collecting evidences and pursuing it for a long time. On the other side, there is a well –equipped and powerful machinery who can afford to create and sustain its defenses.

3.12 PATIENTS AUTONOMY: HUMAN RIGHTS PERSPECTIVE

Patient's rights emanate fundamentally from Human Rights. The underlying concept of Human Rights is that people have inherent rights because they are human beings. [510] WHO's definition of health includes physical, mental, social, environmental and spiritual health.

The Indian Constitution incorporates provisions guaranteeing everyone's right to the highest attainable standard of physical and mental health. Article 21 of the Constitution guarantees protection of life and personal liberty to every citizen. The Supreme Court in *Bandhua Mukti Morcha v. Union of India*[511] has made it candid that the right to live with human dignity, enshrined in Article 21, is derived from the directive principles of state policy and therefore includes

[509] Singh Daljit Singh Gujral v. Jagjit Arora (2014) 41 SCD 269
[510] Michael Peel, *Human rights and medical ethics*, Journal of Royal Society of Medicine, R Soc Med.171-173 98(4) (April 2005).
[511] Bandhua Mukti Morcha v. Union of India. AIR 1984 SC 802

protection to health[512]. Other civil rights, consumer rights, codes of ethics of medical and nursing profession are also protecting patient's rights in India. Basic optimal health care is the right of every Indian citizen and it is the responsibility of the state to provide it. Any threat to health care must be considered as denial of the Right to Life.

The right to self-determination is one of the most important principles of international law [513] Many international human rights documents include rights of self-determination in their lists of basic human rights. This right provides for individual autonomy, human dignity, self-consciousness and the right to choose.[514] Although right to privacy has not been expressly mentioned in the Indian Constitution, it is a part of Article 21 which talks about Right to life and personal liberty. The privacy is that "area of a man's life which in any given circumstances a reasonable man with an understanding of the legitimate needs of the community would think it wrong to invade."[515] This right to privacy has been widely acclaimed and recognized in international documents, such as Article 17 of the International Covenant the Civil and Political Rights, 1966 and Article 12 of the Universal Declaration of the Universal Rights, 1948[516]. This right empowers a patient to refuse treatment. A patient who is competent enough has a right to make his own medical decision according to his wish. The general presumption in medical care cases is that a competent individual has a freedom

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[512] Khandekar et al.,*Right to Health Care*, J Indian Acad Forensic Med., Vol. 34, No. 2 (April-June 2012). http://medind.nic.in/jal/t12/i2/jalt12i2p160.pdf . Last visited on 06-10-2016 at 10.24

[513] Maya Abdullah, *The Right To Self-Determination In International Law*, Master thesis submitted to Department of Law, School of Economics and Commercial Law, University of Goteborg. https://gupea.ub.gu.se/bitstream/2077/1888/1/gupea_2077_1888_1.pdf.Last visited on 6-10-2016 at 10.27

[514] Bineet Kedia & Bhupal Bhattacharya, *The Limits of Autonomy of a Patient in Medical Treatment An Overview*, International Journal and of Management Social Sciences Research (IJMSSR) Volume 2, No. 3, (March 2013). http://www.irjcjournals.org/ijmssr/Mar2013/9.pdf. Last visited on 6-10-2016 at 10.29

[515] Jagruti Dekavadiya, *Whether Section 377 Of Indian Penal Code Is Constitutionally Valid*?, Legal Service India, (2009) .(Last visited on 30-08-2016 at 15.32)http://www.legalserviceindia.com/article/l392-Whether-Section-377-of-IPC-Constitutionally-Valid.html .

[516] India is a signatory to the Universal Declaration of Human Rights, 1948 and the International Covenant on Civil and Political Rights, 1966. Article 12 of UDHR and Article 17 of ICCPR states:

No one shall be subject to arbitrary or unlawful interference with his privacy, family, human or correspondence, or to lawful attacks on his honor and reputation. Everyone has the right to the protection of the law against such interference or attacks**.**

to make his choice and control his destiny under the right to privacy, even when such decision may go against his own interest.[517]

3.13 PATIENT IN THE INFORMATION ERA

India is a country of diversities. Same is true with respect to healthcare sector also. While majority of patients are illiterate and passive participants in the medical practices, the other group, is also very much present. The new age patient is arriving clinic armed with information available on the web. Usage of internet rapidly increased. Not just the basic information, the 'e-patient' has easy access to latest developments, various different treatment models available for the conditions and can make an intelligent choice.[518] The bygone era, due to lack of information, was the period of "Doctor Knows the best". However, in the information age, patients are empowered with information. They are no longer for blind trust and demand information to qualify their trust.[519]

The tremendous advances in medical technology, the high costs of health care, the scarcity of resources, the rise in public expectations and the shift in values require intensive consideration of the future of the health system.[520] Novel situations demand certain and modified legal principles to ensure justice. It is necessary to understand the principles that call for decisions involving health care. It is the responsibility of the law makers to remove the contradictions and uncertainties in the respective arena.

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[517] supra note514.See also,People's Union Of Civil Liberties v. Union Of India And Anr. (1997) 1 SCC 301, " It is almost an accepted proposition of law that the rules of customary international law which are not contrary to the municipal law shall be deemed to be incorporated in the domestic law."

[518] Divekar Sachin & Sukhadeve Varsha , *Doctor-Patient Relationship Worsening in Indian Context*, International Journal of Applied Research & Studies 207, IJARS/ Vol.I Issue II (Sept-Nov, 2012) . https://www.academia.edu/3488490/Doctor-Patient_Relationship_Worsening_in_Indian_Context .Last visited on 30-08-2016 at 15.37

[519] Divekar & Sukhadeve supra note 518

[520] Amnon Carmi,(ed), *Informed Consent*,UNESCO Chair in Bio Ethics, The International Center For Health, Law And Ethics ,Faculty Of Law, University Of Haifa, Israel (2003). http://unesdoc.unesco.org/images/0014/001487/148713e.pdf .Last visited on 30-08-2016 at 15.44.

3.14 CONCLUSION

In *Samira Kohli*'s case, the honorable Supreme Court has expressed that if medical practice becomes more commercialized, and if there is a corresponding increase in the awareness among the public, we may have to move towards Canterbury Principle of Informed consent. An analysis of the current state of health sector, more importantly of the doctor-patient relationship and the awareness level of patients indicates the presence of both these elements and therefore, it is high time, we moved towards the strict standards of informed consent.

By the *Montgomery* decision, *Bolam* Test is out of use and the *Sidaway* judgment is overruled. It is established that informed consent is now part of English law. Courts in Australia, Malaysia, New Zealand, Ireland, and Canada, following common law system have legal system requiring informed consent from the patient's point of view.

Rapid commercialization of medical practice has made patients in India more vulnerable. Hence, there is a dare need of legal protection from paternalistic and arbitrary medical intervention. There is an increasing awareness among the public about their rights and basic information on medicine and treatment as well, due to the internet revolution.

One of the arguments leveled against strict standards of Canterbury principle is that, it will bring in higher cost-structure of American medical care. And patients in India cannot afford it. However as Supreme Court observed maintenance and improvement of public health have to rank high in the list of priority for any government. It is a Constitutional obligation. Therefore strict regulation at all levels is an urgent priority. Along with this there has to be an increase in public funding to make Indian healthcare affordable and reliable as well.

A person's basic rights are established on recognition of his human status, the inviolability of his life and the fact that he was born, and will always be, free. Respect for the values and wishes of the individual is a duty which becomes even stronger if the individual becomes vulnerable. Since the autonomy and responsibility of every person, including those who need health care, are

accepted as important values, reaching or participating in decisions concerning one's own body or health must be recognized as a right[521].For medical practice to be effective there should be concordance between the doctor and patient. This being a fiduciary relationship has its foundation well laid in mutual trust and candor. The doctor is no longer 'God' and patient the blind devotee. Social dimensions are changing and corresponding changes are required in legal system as well.

In, India, there is no specific legislation dealing with standard or adequacy of information provided to a patient before any kind of medical intervention. The formalities which will validate consent and excuse the doctor from liability are scattered in various legislations, such as IPC,Cr.P.C,Medical Termination of Pregnancy Act, Indian Contract Act etc.Ostensively,they are dealing with some special situations specifically dealt under such statutes.Besides,these provisions are technical as they focus on capacity of the patient and other formalities rather than the adequacy of information which will facilitate a decision making at the patient's end. In Indian legal context, requirement of consent is clear but what constitutes an ideal consent is still elusive and subject to interpretations. Whether the time has come for moving to *Canterbury* principle continues to be a subject of academic debate. But the critical question is, 'what is the standard which we want to keep as bench mark for transparency on the part of doctor? 'In a country where individual autonomy is well-recognized by the Constitution, this ambiguity leads to violation of fundamental rights. This position needs to be rectified by adequate and timely law making.

We need to get ahead of the 20th century principles of English law. Nevertheless not to try importing the North American doctrine as such is also advisable. The socio-political situations in which doctor work and patient live in India has to be in background while arriving at the standard. The rampant commercialization of health sector, disparage in public health services, abase in the value of medical education and the dangerous level of information gap are some of the important areas which needs consideration. A comprehensive legislation

[521] supra note 230

clarifying the need, standard and adequacy of valid medical consent is the exigent need of the country.

Chapter IV
DEFICIENCY IN MEDICAL SERVICE UNDER CONSUMER PROTECTION ACT, 1986

CHAPTER IV DEFICIENCY IN MEDICAL SERVICES UNDER CONSUMER PROTECTION ACT, 1986

4.1 INTRODUCTION

Consumer movement in India had its roots in the early part of 20th century with the formation of Passengers and Traffic Relief Association, and Women Graduates Union in Bombay in 1915. [522] Dr Annie Besant and C.Rajagopalachari made efforts to establish citizen groups like the Women's Indian Association and the Triplicane Urban Co-Operative stores.[523] One of the earliest consumer co-operatives which pioneered this movement through co-operative movement was the Triplicane Urban Co-operative Stores in Madras. [524] The movement with its visible campaigns pioneered the establishment of the Consumer Guidance Society of India (CGSI) and the Surat Consumer Association[525].

During the 1970s India witnessed an impetus in consumer movement with more and more organisations joining the endeavour, including the Consumer Education and Research Centre of Ahmadabad, Gujarat (CERC) which later became instrumental in building a strong consumer movement in India. By the end of 1970s, the CERC and CGSI emerged as two pioneering consumer associations at the helm of Indian Consumer Movement. By 1980s, voluntary consumer organisations were seen in every part of the country and the organised presence of the consumer was felt.[526]

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[522] *Down the long road of Consumer Rights*,Business Today,January 20 2002.(Last visited on 03-08-2016 at 20.24).http://archives.digitaltoday.in/businesstoday/20020120/consumer2.html.
[523] *A long crusade to insulate consumers from exploitation.* (Last visited on 03-08-2016 at 20.30) .http://www.creatindia.org/pdf/39.pdf (undated)
[524] R. Balaji, *Triplicane Urban Co-op Society turns 100*,Business Line,(April 9th 2004.). (Last visited on 03-08-2016 at 20.46).
http://www.thehindubusinessline.com/2004/04/09/stories/2004040901101700.htm.
[525] supra note 522
[526] Yakoob C. "*A study on the impact of the consumer protection act 1986 on consumer movement, with special reference to northern districts of Kerala* " Thesis submitted for degree of doctor of philosophy, Department of Commerce and Management Studies , University of Calicut, 1998.
http://shodhganga.inflibnet.ac.in:8080/jspui/bitstream/10603/42815/11/11_chapter%202.pdf
Last visited on 03-08-2016 at 16 .53

On April 9, 1985, the General Assembly of the United Nations, by Consumer Protection Resolution No. 39/248, adopted the guidelines to provide a framework for Governments to use in elaborating and strengthening consumer protection policies and legislations[527]. The objectives of the said guidelines include assisting countries in achieving or maintaining adequate protection for their population as consumers and encouraging high levels of ethical conduct for those engaged in the production and distribution of goods and services to the consumers.[528] The legitimate needs which the guidelines are intended to meet include the protection of consumers from hazards to their health and safety and availability of effective consumer redress.[529]

The Consumer Protection Act was enacted in India in 1986 to protect the interests of consumers. It is one of the most comprehensive and progressive piece of social welfare legislation. This is an umbrella legislation covering all goods and services. Unlike other laws, which are basically punitive or preventive in nature, the provisions of the Act are also compensatory. This statute provides more effective protection to the consumers than any corresponding legislation in force in other developed countries[530]. The Act is intended to provide simple, speedy and inexpensive redressal to the consumers' grievances. It also provides relief of a specific nature and awards compensation, wherever appropriate. The Consumer Protection Act, 1986 has ensured the rights of consumer for safety, information, choice, representation, and redressal and consumer education. The Act provides for exclusive three tier redressal machinery as an alternative to the civil court and other legal remedies available in the country[531].

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[527] Indian Medical Association v. V.P. Shantha 1996 AIR 550, 1995 SCC (6) 651
[528] *IMA Id*
[529] *Id*
[530] Report Of The Working Group On Consumer Protection Twelfth Plan (2012-17) Volume - II Subgroup Report Government Of India Department Of Consumer Affairs Ministry Of Consumer Affairs, Food And Public Distribution. http://planningcommission.gov.in/aboutus/committee/wrkgrp12/pp/wg_cp2.pdf .last visited on 30-08-2016 at 17.04
[531] *Id*

4.2 MEDICAL SERVICE AND CONSUMER PROTECTION

For decades injured patients or their relatives had been extremely reluctant to take legal action against negligent medical practitioners under civi law. The prime reasons for impassivity were the following.[532]

- High expenditure involved in the civil litigation. The Court fee and legal fee had been alarmingly huge in initiating an action for common man.
- The Compensation awarded, in comparison with the effort, time and money was meagre.
- A civil action involved a fair bit of procedural formalities and had an uncertain end.
- Prolonged legal action was capable of affecting, financial, social and health status of the injured party.

The Indian Medical Council Act, 1956 also did not help the injured parties in getting redress. The Act, as amended in 1964, provides for regulation of professional practices and medical education .The function of medical Council reconstituted under the Act is registration of medical practitioners.[533] It is the Indian Medical Council (Professional conduct, etiquette and ethics) Regulation, 2002 which specify regulations, whose violations shall constitute misconduct. Disciplinary action will be taken against the erring doctors on the basis of a complaint and enquiry by peer group.[534] However, the Council is available only at the state headquarters. This made the authority, hardly accessible to the majority.[535] Further, the Council has no power to award compensation for the medical negligence. [536] In short,there was absence of easily accessible and effective mechanism for grievances redressal.[537]

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[532] LAKSHMINATH & SRIDHAR ,*supra note 282*
[533] Indian Medical Council Act,1956
[534] The Indian Medical Council (Professional conduct, etiquette and ethics) Regulation ,2002
[535] *Garnicia* supra note 532.
[536] Indian Medical Council Act,1956
[537] The Briefing Paper(GRANIRCA 2/ 201**1)** . (Last visited on 28-04-2016 at 17.48) http://www.cuts-international.org/CART/GRANIRCA/pdf/Briefing_Paper11-Medical_Services_and_Consumer_Protection_Act.pdf

The Consumer Protection Act, 1986 (COPRA) has the unique distinction of being the only one in the country made exclusively for consumers to protect their interests against defective goods and deficient services, even though a plethora of existing legislations do have provisions to deal with consumer rights in different degrees on specified matters.[538] The Act has been marginally amended in 1991 and substantially in 1993 and 2001, with a view to making it more effective in bringing justice to the door steps of consumer[539].The provisions of the Act are in addition to and not in derogation of the provisions of any other law for the time being in force.[540]

The Act ensures protection to the consumer against defect in goods, deficiency in service, excess price, hazardous goods unfair trade practice or a restrictive trade practice [541] The expression "complainant" is defined to include the consumer as well as any registered voluntary consumer association, or the Central Government or any State Government or one or more consumers together.[542]A three-tier structure for the redressal of consumer grievances is set up. At the lowest level, i.e., the District level is the Consumer Disputes Redressal Forum known as 'the District Forum'; at the next higher level, i.e., the State level, is the Consumer Disputes Redressal Commission, i.e., 'the State Commission' and at the highest level is 'the National Commission'.[543]The jurisdiction of these three Consumer Disputes Redressal Agencies is based on the pecuniary limit of the claim made by the complainant. An appeal lies to the State Commission against an order made by the District Forum[544] and an appeal to the National Commission against an order made by the State Commission.[545]. The State Commission can exercise revisional powers on grounds similar to those contained in Section 115 Civil Procedure Code.[546] The National Commission also has similar revisional jurisdiction in respect of a consumer

[538] *Garnicia* supra note 532
[539] *Id*
[540] Section 3 of COPRA,1986
[541] Section 2(1)(c),*Id*
[542] Section 2(1)(b)
[543] Section 9 Id
[544] Section 15 *Id*
[545] Section 19 *Id*
[546] Section 17(b)

dispute pending before or decided by a State Commission. The Act contains a provision to go on appeal to Supreme Court from the order of National Commission.Similarly,an appeal to the National Commission on a complaint or against the order of a State Commission.[547] The Act provides that District Forum [as well as the State Commission and the National Commission] shall be empowered with the same powers as are vested in a civil court under the Code of Civil Procedure. These powers are extended as far as summoning and enforcing attendance of parties and examining the witness on oath; discovery and production of any document or other material object producible as evidence; the reception of evidence on affidavits; the requisitioning of the report of the concerned analysis or test from the appropriate laboratory or from any other relevant source, issuing of any commission for the examination of any witness and any other matter which may be prescribed.[548] Section 14 makes provisions for issue of orders in the nature of reliefs that can be granted to the complainant. It includes provision for removal of defects / deficiencies replace goods, discontinue unfair trade practice or payment of compensation etc.[549]

4.2.1 MEANING OF TERMS

Consumer:-Definition of the expression `consumer' contained in Section 2(1) (d) in so far as it relates to services means any person who:

> ….. hires [or avails of] any services for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such services other than the person who hires [or avails of] the service for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person."

[547] Section 23
[548] Section 13 (4),*IMA* supra note 527
[549] *IMA* supra note 527

In the case of death of patient who is a consumer, legal heirs of the deceased patient will be considered as consumer.[550] Donation collected from a patient is not treated as consideration for the professional services rendered by doctors[551].

Service:-In *Indian Medical association's* [552] case, it was observed that the definition of the term 'service' in Section 2(1) (o) of the Act can be split up into three parts The main part, the inclusionary part and the exclusionary part. The main part is explanatory in nature and defines service to mean service of any description which is made available to the potential users. The inclusionary part expressly includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical of other energy, board or lodging or both housing construction, entertainment, amusement or the purveying of news or other information. The exclusionary part excludes rendering of any service free of charge or under a contract of personal service[553]. Section 2(1) (g) defines:

> deficiency" of service as , "any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service

The definition of `service' as contained in Section 2(1) (o) of the Act has been construed by the Supreme Court in *Lucknow Development Authority v. M.K. Gupta,*[554]The court observed:

> The main clause itself is very wide. It applies to any service made available to potential users. The words `any ' and `potential' are significant. Both are of wide amplitude. The word `any' dictionary means; one or some or all', In Black's Law Dictionary it is explained thus, "word `any' has a diversity of meaning and may be employed to indicate `all' or `every' as well as `some' or `one' and its meaning in a given statue depends upon the context and the subject- matter of the statute". The use of the word `any' in the context it has been used in clause (o) indicates that it has been used in wider sense extending from

[550] Cosmopolitan Hospital v. Vasantha P. Nair, 1 (1992) CPJ 302(NCDRC).
[551] C.V. Madhusudhana v. Director, Jayadeva institute of Cardiology,II (1992) CPJ 519 (Karnataka SCRDC)
[552] *IMA* supra note 527
[553] *IMA* supra note 527
[554] 1994 (1) SCC 243

> one to all. The other word `potential' is again very wide. In Oxford Dictionary it is defined as `capable of coming into being, possibility'. In Black's Law Dictionary it is defined "existing in possibility but not in act. Naturally and probably expected to come into existence at some future time, though not now existing; for example, the future product of grain or trees already planted, or the successive future instalments or payments on a contract or engagement already made.

In other words service, which is not only extended to actual users but those who are capable of using it are covered in the definition. The clause is thus very wide and extends to any or all actual or potential users."

Deficiency in Service:-According to section 2 (g):

> deficiency means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.

The test to determine whether there is deficiency of service is the same as that is applied in action for damages for negligence.

4.2.2 DEFICIENCY IN MEDICAL SERVICE

Medical negligence is deficiency in service. There can also be cases, not involving negligence, but can constitute deficiency in service For example, the surgeon is involving in some unfair practices, collecting excess charge, falsely claiming qualification etc.[555]. Loss or injury caused due to deficiency in service will make hospitals and doctors liable for compensation. The inclusive part of the definition of 'service' under the Act was positively used by various courts. The Supreme Court in *Lucknow Development Authority* case[556], observed that:

> ..... the entire purpose of widening the definition is to include in it not only day to day buying and selling activity undertaken by a common man but even such activities which are otherwise not commercial in nature yet they partake of a character in which some benefit is conferred on the consumer.

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[555] RAO supra note 36
[556] 1994 (1) SCC supra note

The critical question that whether a medical practitioner can be regarded as rendering 'service' under Section 2(1)(o) of the Consumer Protection Act, 1986 was considered by various High Courts as well as by the National Consumer Disputes Redressal Commission (National Commission),earlier.The National Commission in 1992, in *Cosmopolitan Hospital and Anr. v. Vasantha P. Nair*[557] held that the activity of providing medical services for payment carried on by the hospital and members of the medical profession, falls within the scope of the expression 'service' as defined in Section 2(1) (o) of COPRA and in the event of any deficiency in the performance of such service, the aggrieved party could invoke the remedies provided under the Act by filing a complaint before the consumer forum having jurisdiction. A patient can seek redressal from a consumer court for medical services under the following circumstances:

- the services should have been hired or availed of or agreed to be hired or availed of by the patient
- the services should have been rendered or agreed to be rendered by the doctor to the patient
- the services of the doctor should have been or availed of or agreed to have been hired or availed of for consideration
- the services of the doctor so hired or availed of or agreed to be hired or availed of suffer from deficiency in any respect
- the services have not been rendered free of charge or under a contract of personal service

A patient who pays up for the treatment, or promises to do so with a consideration can seek redressal in a consumer court. The Commission affirmed that:

> In the case of hospitals which provide treatment to patients for payment we are unable to see how there is any element of personal service involved in such an arrangement. When a patient goes to such a hospital and avails himself of the facility of treatment on payment of consideration, be is dealing only with an institution carrying on the activity of providing medical service for payment and no element of 'personal service' does enter into the picture in such a case. The hospital

[557] (1992) CPJ 302 NC

> may have its own lectors, consultants etc. for treating the patients admitted to its care but ordinarily it is not likely that there will be privity of relationship between the person who gets admitted in the institution and the doctors' who may be on the staff of the institution or may be visiting consultants there. In the light of the foregoing discussion, we have no hesitation to uphold the finding of the State Commission that the activity of providing medical assistance for payment carried on by hospitals and members of the medical profession falls within the scope of the expression 'service' as defined in Section 2 (1) (0) of the Act and that in the event of any deficiency in the performance of such service the aggrieved party can invoke the remedies provided under the Act by filing a complaint before the Consumer Forum having Jurisdiction.[558]

In *A.S. Chandra v. Union of India,*[559] Andhra Pradesh High Court has held that service rendered for consideration by private medical practitioners, private hospitals and nursing homes must be construed as 'service' for the purpose of Section 2(1)(d) of the Act and the persons availing such services are 'consumers' within the meaning of Section 2(1)(d) of the Act.

In this case, it was argued that professional services rendered by medical practitioners do not fall within the purview of ‘complaint’ under Section 2(b) of the Consumer Protection Act, 1986. The expression ‘service’ as defined by Section 2(o) of the Act excludes professional services rendered by members of the medical profession. It was contended that, bringing, medical services, within the purview of Section 2(o) of the Act would be unconstitutional being violative of Article 14 of the Constitution. Further argument was that the consumer forum is not the proper forum to decide the question since; in this case, the allegations levelled by the fourth respondent constitute a tortious act, the adjudication of which requires receiving of elaborate evidence and consideration of complicated medical norms. Hauling up of doctors before Consumer Forums in respect of the professional services rendered by them for consideration would be violative of Article 19(1) (g) of the Constitution also.

The learned judge negated all the pleas and dismissed the writ petition holding that the bodies entrusted with the administration of the Act consist of and presided over by persons with matured judicial training. The choice of the

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[558] See also, Dr. Sr. Louie. v. Smt. Kannolil Pathumma & Anr. I (1993) CPJ 30(NC)
[559] (1992) 1 Andhra Law Times 713

personnel itself indicates that there are inbuilt safeguards. It was observed that, "Merely because the provisions of the Indian Medical Council Act provide for disciplinary action against an erring medical practitioner there is nothing to hold that the jurisdiction of the District Forum is ousted under the provisions of the Act." Except where services were rendered free of charge or under a contract of personal service, all the other services are comprehended, by Section 2(o) of the Act.

However, in *C.S.Subramanian v. Kumaraswamy*,[560]the Madras High Court has taken a narrow view. It has been held that the services rendered to a patient by a medical practitioner or by a hospital by way of diagnosis and treatment, both medicinal and surgical, would not come within the definition of 'service' under Section 2(1) (o) of the Act. It was concluded that patient who undergoes treatment under a medical practitioner or a hospital by way of diagnosis and treatment, both medical and surgical, cannot be considered to be a `consumer' within the meaning of Section 2(1) (d) of the Act. But the medical practitioners or hospitals undertaking and providing paramedical services of all kinds and categories cannot claim similar immunity from the provisions of the Act and that they would fall, to the extent of such Para-medical services rendered by them, within the definition of `service' and a person availing of such service would be a `consumer' within the meaning of the Act.

This matter been settled by the landmark judgment of the Supreme Court in the case of *Indian Medical Association v. VP Shantha & others.* [561]

IMA: The land mark

Following the contradictory decisions from various High Courts and Consumer forums ,there was an efflux of Special Leave Petitions in front of Supreme Court.These Petitions were mainly for the purpose of clarity and a certain answer to the question, 'whether medical services will come within the purview of 'services' under COPRA 1986?'

[560] (1994) 1 MLJ 438
[561] *IMA* supra note 527

Writ Petition No. 16 of 1994 has been filed under Article 32 of the Constitution by Cosmopolitan Hospital (P) Ltd., and Dr. K. Venogopolan Nair [petitioners in SLP(C) Nos. 6885 and 6950/92] wherein the said petitioners have assailed the validity of the provisions of the Act, insofar as they are held to be applicable to the medical profession, as being violative of Articles 14 and 19(1) (g) of the Constitution[562]

AGRAWAL, S.C. (J) in his celebrated judgement analysed and interpreted, the back ground, objectives and reach of the Act and various provisions as related to the main contention that is applicability of COPRA to medical services.

Occupation, not Profession

In this case, the main argument was based on the distinction between the expressions, a profession and an occupation.It was argued that, while a person engaged in an occupation renders service which falls within the ambit of Section 2(1) (o), the service rendered by a person belonging to a profession does not fall within the ambit of the said provision. Therefore, medical practitioners who belong to profession are not covered by the provisions of the Act. It was put across that medical practitioners are governed by the provisions of the Indian Medical Council Act, 1956 and the Code of Medical Ethics made by the Medical Council of India. Section of the Indian Medical Council Act, 1956 regulates their conduct as members of the profession and provides for disciplinary action. However, the Court observed that

> … medical practitioners, though belonging to the medical profession, are not immune from a claim for damages on the ground of negligence. The fact that they are governed by the Indian Medical Council Act and are subject to the disciplinary control of Medical Council of India and/or State Medical Councils is no solace to the person who has suffered due to their negligence and the right of such person to seek redress is not affected.

Capability of the Forum

[562] *IMA Id*

Another contention in favour of the doctors was that the Consumer Fora have only summary jurisdiction. They cannot deal with the complex issues of law which may arise for determination.

In addressing this issue, the Court referred to the two divergent views expressed by Prof. White in his book titled, 'The Administration of Justice.'

> One view holds that lay adjudicators are superior to professional judges in the application of general standards of conduct, in their notions of reasonableness, fairness and good faith and that they act as 'an antidote against excessive technicality' and 'some guarantee that the law does not diverge too far from reality. The other view, however, is that since they are not experts, lay decision makers present a very real danger that the dispute may not be resolved in accordance with the prescribed rules of law and the adjudication of claims may be based on whether the claimant is seen as deserving rather than on the legal rules of entitlement.

Tribunal composed of a lawyer, as Chairman, and two lay members is preferred over a court composed of only judicial officers. Such a Tribunal would present an opportunity to develop a model that combines the merits of lay decision making with legal competence. Apart from their breadth of experience, the key role of lay members would be in ensuring that procedures do not become too technical. It will make the proceeding more transparent and conceivable to litigants for whose benefit it is designed. That would lead to general public confidence in the fairness of the process [563]

The design of composition of the redressal agencies under COPRA, 1986 are in fact fulfilling this criterion. The Act provides that the President of the District Forum shall be a person who is or who has been or is qualified to be a District Judge and the other two members shall be persons of ability, integrity and standing, having adequate knowledge or experience or, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration and one of them shall be a woman.[564] Similarly, the President of the State Commission shall be a person who is or who has been a Judge of a High Court appointed by the State Government in consultation with the Chief Justice of the High Court and that

[563] *IMA* supra note 527
[564] Section 10 of COPRA

the other two members shall be persons of ability, integrity and standing, having adequate knowledge or experience of, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration, and one of them shall be a woman[565].Setion 20 of the Act states about of the composition of the National Commission is governed by Section 20 of the Act. The President of the Commission shall be a person who is or who has been a Judge of the Supreme Court to be appointed by the Central Government after consultation with the Chief Justice of India and four other members shall be persons of ability, integrity and standing having adequate knowledge or experience of, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration and one of them shall be a woman.

The Court observed that,

> …Consumer Disputes Redressal Agencies are headed by a person who is well versed in law and has considerable judicial or legal experience. It has, however, been submitted that in case there is difference of opinion, the opinion of the majority is to prevail and, therefore, the President may be out-voted by the other members and that there is no requirement that the members should have adequate knowledge or experience in dealing with problems relating to medicine. … the presence of a person well versed in law as the President will have a bearing on the deliberations of these Agencies and their decisions….Since the goods or services in respect of which complaint can be filed under the Act may relate to number of fields it cannot be expected that the members of the Consumer Disputes Redressal Agencies must have expertise in the field to which the goods or services in respect of which complaint is filed, are related. …. It cannot, therefore, be said that since the members of the Consumer Disputes Redressal Agencies are not required to have knowledge and experience in medicine, they are not in a position to deal with issues which may arise before them in proceedings arising out of complaints about the deficiency in service rendered by medical practitioners.

Locus standi

Consumer Protection Act, 1986, deals with the nature of disputes consumer forum can entertain, who can initiate complaint, relief it can grant and its jurisdiction in detail. It is a quasi-judicial body and therefore the jurisdiction is

[565] Section 16 of COPRA

limited. The Act defines the term 'complaint'[566] as any allegation in writing made by a complainant that— an unfair trade practice or a restrictive trade practice has been adopted by any trader or service provider

- the goods bought by him or agreed to be bought by him; suffer from one or more defects
- the services hired or availed of or agreed to be hired or availed of by him suffer from deficiency in any respect
- a trader or service provider, as the case may be, has charged for the goods or for the service mentioned in the complaint a price in excess of the price
- fixed by or under any law for the time being in force
- displayed on the goods or any package containing such goods ;
- displayed on the price list exhibited by him by or under any law for the time being in force;
- agreed between the parties;
- goods which will be hazardous to life and safety when used or being offered for sale to the public,
- in contravention of any standards relating to safety of such goods as required to be complied with, by or under any law for the time being in force;
- if the trader could have known with due diligence that the goods so offered are unsafe to the public

Section 2 (b) of the Act defines a 'complainant' as (i) a consumer; or (ii) any voluntary consumer association registered under the Companies Act, 1956 (1of 1956) or under any other law for the time being in force; or (iii) the Central Government or any State Government, (iv) one or more consumers, where there are numerous consumers having the same interest.a,b and c of subsection (1) of Section 12 enable a complaint to be filed by:-

[566] Section 2(c) of COPRA

- the consumer to whom such goods are sold or delivered or agreed to be sold or delivered or such service provided or agreed to be provided;
- any recognised consumer association whether the consumer to whom the goods sold or delivered or agreed to be sold or delivered or service provided or agreed to be provided is a member of such association or not;
- one or more consumers, where there are numerous consumers having the same interest, with the permission of the District Forum, on behalf of, or for the benefit of, all consumers so interested; or the Central Government or the State Government, as the case may be, either in its individual capacity or as a representative of interests of the consumers in general.

Contract 'for' Service

The contention that, the relationship between doctor and patient is that of trust and confidence and therefore falls within the ambit of 'contract of personal service' was clipped by the apex Court[567]. Citing decisions in *Dharangadhara Chemical Works Ltd. v. State of Saurashtra*,[568] and *Simmons v. Heath Laundry Co*. [569] the Court affirmed that:

> ….A `contract for services' implies a contract whereby one party undertakes to render services e.g. professional or technical services, to or for another in the performance of which he is not subject to detailed direction and control but exercises professional or technical skill and uses his own knowledge and discretion… A `contract of service' implies relationship of master and servant and involves an obligation to obey orders in the work to be performed and as to its mode and manner of performance... We entertain no doubt that Parliamentary draftsman was aware of this well accepted distinction between "contract of service" and "contract for services" and has deliberately chosen the expression `contract of service' instead of the expression `contract for services', in the exclusionary part of the definition of 'service' in Section 2(1)(o).

A contract of personal service involves a master and servant relationship which is wholly different from a medical doctor-patient relationship. A medical

[567] *IMA* supra note 527
[568] 1957 SCR 152
[569] (1910) 1 K.B. 543

officer's service may be personal at times, but it will be incorrect to call it as 'personal service'. The service rendered by a medical doctor to his patients is not 'personal service' within the purview of exempted category mentioned in Section 2(l) (o)[570]. In the case of hospitals which provide treatment to patients for payment, the patient is dealing only with an institution providing medical service. There is no element of 'personal service' in such a case. The hospital has its own staff including doctors. But there is no privity of relationship between the person who gets admitted in the institution and the doctors who may be on the staff of the institution.[571].

> It is no doubt true that the relationship between a medical practitioner and a patient carries within it certain degree of mutual confidence and trust and, therefore, the services rendered by the medical practitioner can be regarded as services of personal nature but since there is no relationship of master and servant between the doctor and the patient the contract between the medical practitioner and his patient cannot be treated as a contract of personal service but is a contract for services and the service rendered by the medical practitioner to his patient under such a contract is not covered by the exclusionary part of the definition of `service' contained in Section 2(1)(o) of the Act.[572]

Medical Service is 'Service'

The Supreme Court stated the law as,

- Service rendered to patient by a medical practitioner except where doctor render service free of charge to every patient or under a contract of personal service by way of consultation, diagnosis & treatment, both medicinal & surgical would fall within the ambit of "service" as defined in Section 2(1) (0) of the COPRA.
- The fact that medical practitioners belong to medical profession and are subject to the disciplinary control of the Medical Council of India and State Medical Councils would not exclude the service rendered by them from the ambit of the COPRA.

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[570] *Cosmopolitan Hospital* supra note 550
[571] *Cosmopolitan Hospital Id*
[572] *IMA* supra note 527

- The service rendered by a doctor is under a contract for personal service and not covered by the exclusionary clause of the definition of service contained in the COPRA.
- Service rendered free of charge to everybody, would not be service as defined in the Act. The hospitals and doctors cannot claim it to be a free service if the expenses have been borne by an insurance company under medical care or by one's employer under the service condition.
- Where, as a part of the conditions of service, the employer bears the expenses of medical treatment of an employee and his family members dependent on him, the service rendered to such an employee and his family members by a medical practitioner or a hospital/nursing home would not be free of charge.
- Service rendered at a non-Government hospital/Nursing home where charges are required to be paid by persons who are in a position to pay and persons who cannot afford to pay are rendered service free of charge would fall within the ambit of the expression 'service' under the Act.

4.2.3 SURGERY

Surgery is a medical treatment in which a doctor cuts into someone's body in order to repair or remove damaged or diseased parts[573]. It is a profession defined by its authority to cure by means of bodily invasion[574].

According to Hindu mythology, the creator of the Universe, Lord *Brahma*, is considered to be the first compiler of medical knowledge. It is believed that it was Lord *Indra* who passed on this knowledge, the "science of life", to sages and they, in turn, taught this subject to others. *Atreya*,who was believed, to have lived in the period 700 - 600 B.C became a renowned teacher at *Taxila* [575] .*Sushruta*, one of his disciples attained great proficiency in

[573] Mariam-Wbster Dictionery.http://www.merriam-webster.com/dictionary/surgery. Last visited on on 19-02-2016 at 12.26
[574] Atul Gawande, *Two Hundred Years of Surgery*, N Engl J Med 1716-1723, 366 (May 3 2012). http://www.nejm.org/doi/full/10.1056/NEJMra1202392#t=article .Last visited on 30-08-2016 at 17.30
[575] Arun Prasad,*From prehistoric time to latest developments*,Sugery Times. (Last visited on 30-08-2016 at 17.37) http://surgerytimes.com/history/ancient.html (Blog)

surgery[576].This sage who lived nearly 150 years before Hippocrates vividly described the basic principles of surgery in his famous ancient treatise '*Sushruta Samhita'.*[577]The *Sushruta Samhita* is considered to be the most advanced compilation of surgical practices of its time. It contains composite teachings of the surgery and all the allied branches including midwifery making it a comprehensive treatise on the entire medical discipline[578].

This medical procedure has a history which dates back to the Neolithic and pre-Classical ages. There are evidences that this was practiced as early as 3000 BC and continued through the middle ages and into the Renaissance.[579]Surgeons of the middle ages were barber-surgeons mostly dealing with tooth extraction and war wounds. Apart from the fact that they learned only through apprenticeship and observation, surgery remained risky due to the absence of adequate anaesthetics and antiseptics also.[580] With advent of use of anaesthesia in the late 1800s, horror of pain of an operation has disappeared. However, the threat of infection still meant death for some[581].

In the 20th century, there were important inventions in science and medicine. The most difficult surgeries on the brain and the heart developed during this time. The first pacemaker was made in 1958, the first heart transplant was performed in 1967, the first artificial heart was installed in 1982 and the first heart and lung transplant was performed in 1987.Laser was invented in 1960 and in 2008 it was used to treat brain cancer in keyhole surgery.[582]

Surgery has developed as a critical component of medical culture in last century. And it has gradually established its inescapable presence as an essential tool for

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[576] *Id*
[577] S Saraf, R Parihar. *Sushruta: The first Plastic Surgeon in 600 B.C.*. The Internet Journal of Plastic Surgery. Volume 4 Number 2(2006). http://ispub.com/IJPS/4/2/8232. Last visited 1-08-2016 at 17.16
[578] *Id*
[579] Aurelia Clunie, *Surgery...a Violent Profession*, Stage Notes, Hartford Stage Notes,(Sep 11-Oct 5,2014). https://www.hartfordstage.org/stagenotes/ether-dome/history-of-surgery. Last visited on 30-08-2016
[580] *Id*
[581] *Id*
[582] Tim Lambert, *A brief history of surgery*(2013). (Last visited on 01-08-2016 at 17.37) http://www.localhistories.org/surgery.html.

healthy life. The increased safety and ease of surgery have produced an explosion in the volume of operations being performed.[583] This evolution has brought other tasks such as ensuring the quality and appropriateness of the procedures performed, access to surgical care etc. The concern became intense, in the light of large scale commercialisation of health sector, with wide differences in outcomes among institutions, and large disparities in access to care both within and between countries.[584] The brutality and risks of opening a living person's body has apparently attracted great amount of attention from various sectors, social, political and legal.[585]

According to the Indian Medical Council Act, medicine means modern scientific medicine in all its branches and includes surgery and obstetrics, but does not include veterinary medicine and surgery. Courts have often observed that what is expected from a surgeon is ordinary skills of a man of his own profession and they cannot be held liable by the 'stretch of imagination'[586].

Every surgical operation is fraught with risk. No operation can be considered to be safe as any complication, during the operation may appear any time. The more the invasiveness, the greater the risk. No two human bodies are exactly alike. Each has its own deviation and distinctive features. Human bodies are as individual and different in their details as are human beings. This is so in best of centres all over the world and with best of surgeons. This has also been accepted by the courts and reiterated in their judgments.[587] In number of decisions Supreme Court, various High Courts, State Commission and National Commission has made candid explanations in respect of liability of doctors and hospital while performing a surgery. The main reason for dissatisfaction of the patient following surgery is lack of proper communication between doctor and patient.

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[583] Atul Gawande, supra note574
[584] Atul Gawande, supra note 574
[585] Atul Gawande, supra note 574
[586] *Poonam verma,Supra note 20Jacob Mathew* supra note13
[587] Saroj Chandhoke v. Sir Ganga Ram Hospital III (2007) CPJ 189 NC

4.2.4 PRE-SURGICAL PROCEDURE AND CARE

It was stated by Lord FRASER[588] that an error of judgment is not negligence. The Supreme Court in *Spring Meadows Hospital's* case[589] observed that an error of judgment is not necessarily negligence, but gross medical mistake will be. In *R.C.Sharma's* case, the National Commission observed that, a mere error of judgment by a surgeon cannot be considered as negligence.[590]

The true position is that an error may or may not be negligence, as observed in *White house v. Jordan*[591].But negligence is an error which an ordinarily skilled person could not have been made in that situation. As stated by the Supreme Court in *Jacob Mathew's* case[592],a surgeon does not undertake to cure but only to use the highest possible degree of skill-fair, reasonable and competent.

The National Commission in 1998 observed that inadequate preparation for surgery is deficiency in service. The defendants in this particular case failed to keep blood in adequate quantity.Morover mechanically operated artificial respirator, and a lone needle for inter cardiac injection which are necessary before performing surgery in cases similar to that of complainant-patient, was also not available. The doctors were held liable for conducting an operation without making adequate diagnosis, proper investigation, and required arrangements.[593]

In *S.Kishan Rao's* case[594], the patient complaining of chest pain was admitted to the nursing home and was diagnosed with Benign Cystic of Breast. She had undergone an operation after the pathologist issued report. She developed a lump in her right breast six months after discharge and removal of that required another surgery. Again another lump developed in the same breast and the opposite party referred her for radiotherapy. The Commission held that the hospital was lacking infrastructure and facilities in rendering treatment to a

[588] White house v. Jordan 1980 (1) All ER 650,
[589] Spring Meadows Hospital v. Harjol Ahluwalia AIR 1998 SC 1801
[590] R.C.Sharma v. Jageram, 2003(1 CPJ 248(NC))
[591] *Whitehouse* supra note 588
[592] *Jacob Mathew* supranote 13
[593] Rashmi R. Fadnavis . v. Mumbai Grahak Panchayat 1998 (3) CPJ21 (NC)
[594] S.Kishan Rao v.Sudha Nursing Home III (2001) CPJ 478.

cancer patient which coupled with the negligence of the treating doctor amounts to deficiency in service.

In a matter decided by the Karnataka State Commission, it was held that there is deficiency in service on the part of the surgeon, if he has not taken required preparations before undertaking an operation. An emergency surgery called cholecystitistomy for removal of gall bladder was conducted which was followed by profuse bleeding from the operated part. Patient was taken for a second operation to stop bleeding. The condition worsened and patient had to be shifted to another hospital and on the way the patient died. The State Commission found that instead of immediately shifting to another hospital, the doctors mishandled the situation.[595]

In *Sailesh Munja's* case,[596] The National Commission observed that there is a thin line difference between an error, imperfection or fault and negligence. It was also observed that before performing surgery, the operating surgeon should invariably carry out pathological and laboratory tests to ascertain the condition of the patient. In this case surgeon failed to detect ulcer in uterus by way of pre-operative assessment. The surgeon argued that conducting tests to assess patient's condition was not necessary as the patient was thoroughly examined by gynaecologist .This was not accepted as justification for not conducting pre-operative assessment.[597]

In another case, a planned surgery was performed after a thorough biopsy. Immediately after the operation, the patient suffered from paralysis. National Commission found that, there was serious lack of proper appreciation and assessment of neurological implications of pathology. This shows absence of pre-operative care. The situation resulted in operative care also, as there was not a nuero-surgeon, completely involved during the operation which worsened the situation. Held a clear case of deficiency in service[598].Madhya Pradesh State Commission found the anaesthetist and the surgeon to be negligent for want of

[595] A.Xavier v. Cantonment Politechnic 2005 CTJ 686 (kar)
[596] Sailesh Munja v. All India Institute of Medical Sciences, 2004(3) CPJ
[597] Kali Gounder v. N.Thangamuthu 2004 (3)CPJ29 (NC)
[598] Prashant Dhanaka v.Nizam's Institute of Medical Sciences and Ors, 1999(1) CPC 404

pre-operative care in not preparing the patient for anaesthesia which resulted in aspiration of the lungs resulting in the death of a patient.[599]

A patient suffering from fever, cough and pain in the chest was operated in abdomen without attempting to make a thorough diagnosis. The operation resulted in malignancy in the abdomen. The State Commission held the doctor and hospital liable for negligence[600].Hospital was found to be negligent for not keeping 'A' negative blood group ready at the time of operation.[601]

Conducting operation without X-ray report and necessary pathological reports was held to be deficiency in service by Jharkhand State Commission[602]. In this case, a patient having gynaecological problem was advised a surgery for removal of uterus. The patient was operated on the same day on which she was admitted, without adequate pathological pre-assessment. The patient died of renal failure and septicaemia.Operating for cataract without assessing whether the patient is diabetic and not conducting adequate tests to verify the same was held to be deficiency in service.[603]

Babu Rao Vithal's is a case where a 38 years old patient was admitted to the hospital for hysterectomy and taken to the operation theatre at 1.40 pm and was declared dead at 3.00 p.m. before the commencement of surgery in the presence of anaesthetist, gynaecologist, nurse and the surgeon as also a chest specialist who came to the operation theatre a few minutes before her death. The National Commission held that treating doctors had taken ordinary precaution nor did they exhibit average skill possessed by an average surgeon or an anaesthetist and that no pre-aesthetic check-up was conducted. It was held that the negligence of the anaesthetist in administering anaesthesia has resulted in cardiac arrest of the patient.[604]Not conducting pre-operative investigations for

[599] Bhanu Pal v. Dr.Prakash Padode and Ors., 2000 (2) CPJ 384 (MP)
[600] I.K.Raju v. M.Ramalakshmi, 2003 (6) CLD 502 (AP)
[601] K.Satyanarayana v. Lakshmi Nursing Home 2003 CTJ 1018 (AP)
[602] Dr.Dwivedi Pannag Bhooshan v. Balaram Kumar Singh, 2004 CTJ 261 (Jharkhand)
[603] Christian Medical Centre v. A Shajahan, 1998 ALD (Cons) 28
[604] Baburao Vithal Lohakpure v. Yuvraj Lohakpure , decided by the National Commission on 16.08.2007

intra-ocular operations like cataract and Glaucoma was also held to be deficiency in service by National Commission[605].

In *C.P. Sreekumar v. S. Ramanujam* ,[606] pre-operative evaluation was made. The physician has explained the various options available and received the consent of the patient. He decided to perform a hemiarthroplasty instead of an internal fixation procedure. The patient filed a complaint for medical negligence for not opting internal fixation procedure. The Supreme Court held that the physician's decision for choosing hemiarthroplasty with respect to a patient of 42 years of age was not so palpably erroneous.The case was held not to be one of professional negligence.

4.2.5 PRACTICE OF DEFENSIVE MEDICAL PROCEDURE

Defensive medical procedure is a precaution of physician against the threat of being wrong. It consists of adopting procedures which are not for the benefit of the patient but safeguard against the possibility of the patient making a claim of negligence[607].

This can be Positive and Negative defensive medicine. Positive mechanism includes undertaking additional procedures such as diagnostic tests,X-rays,sophisticated diagnostic imaging,endoscopies,repeated investigations which are in doctors professional judgment, unnecessary.Similarly,Caesarian section even when not necessary, over prescription, prolonging stay in hospital, excess record keeping leading to anticipatory forgery of the data etc are also waste of time, money and resources. Further it increases the risk of medical intervention to patients[608].

Negative defensive medicines involves avoiding emergency and high risk cases and avoiding procedures which are involving risk which in the doctor's professional judgment necessary in the interest of the patient. The term

[605].R.K.Akhouri v. Sh.K.N.Lal 2003 CTJ 761 (NC) (CP)
[606] (2009) 7 SCC 130
[607] SINGH &BHUSHAN supra note 123
[608] *Id*

defensive medical practice is adopting measures which are but not medically required or ethical. It is claimed that this is done 'to play safe'[609].

However, the standard of care expected from a medical professional is applicable in this case also. When a medical practitioner is prescribing tests which are not routine and unnecessary or refuses to undertake or avoids a procedure which is necessary in the interest of the patient, he is falling below the reasonable standard of his profession and such practice amounts to deficiency in service[610].At the same time ,if due to the nature of the illness, which is often not detected till an advance stage through blood tests, patient could not be saved, it cannot be attributed to medical negligence[611].In *Chand Kishore Rajput v. Sood Stone Clinic*[612]the National Commission reiterated the views expressed by the Apex Court. While explaining the principle, it was observed that "the law does not require a doctor to act perfectly ,but rather the law requires that a doctor take reasonable care in treating and advising a patient.This is not a high or impossible standard to achieve." Similarly it was also observed that merely because a doctor chooses one cause of action in preference to other one available, he would not be liable if course of action chosen by him was acceptable to medical profession.[613]

4.2.6 PERFORMANCE OF SURGERY

A doctor cannot be held negligent, if he has acted with normal care, in accordance with the recognised practice accepted as proper by responsible body of medical men. However, when the doctor professes that he is specialist, possessing some special skill, he is expected to exercise, high degree of care than general practitioner, whose conduct is to be judged on different parameter, reiterated the national Commission[614]

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[609] *Id*
[610] *Id*
[611] G.K.Sabharwal v. Sathish Virmani III(2013) CPJ 95 (NC)
[612] I(2015) CPJ 101(NC)
[613] A.Parameshwar v. Asian Institute of Gastroenterology I (2015)CPJ113(NC)
[614] Baidya Nath Chakraborty v.Chandi Bhattacharjee II(2014)CPJ 601 (NC)

Failure to take precaution to avoid a risk will not be characterised as negligence[615].The National Commission in *Poona medical Foundation Ruby Hall Clinic v. Maruti Rao L.Titkare*[616] has held that there can be no question of negligence by reason of failure to supply hospital records pertaining to the surgical operation performed unless a legal duty is cast on the hospital to furnish such document.The National Commission has observed that in the case of operation being performed, it is the duty of the institution to provide post – operative treatment and care to the patients[617].

In *Leelamma Joseph's* case,[618] the complainant, a housewife, had undergone the surgery.Following complications, she had to undergo five major surgeries in a span of 140 days.It was an attempt to repair the urinary bladder which had been cut into four during surgery, resulting in permanent leakage of urine. Apart from the huge financial loss the family suffered, she had to undergo mental trauma, which has severely compromised her quality of life.

The complainant deposed before the Commission that the severe damage she suffered had been due to the negligence of the doctor, who had decided to opt for a 'Laparoscopically Assisted Vaginal Hysterectomy' (LAVH) without the informed consent of the patient.

It was found by the Kerala State Commission that that a huge amount had been spent by the complainant for the above surgeries apart from the trauma and other sufferings undergone by the complainant and her relatives. It is further observed that the complainant had been in the hospitals for about 140 days and even now the complainant is having complaints to control the urine which may fail at any time. Therefore it was held that complainant has to be compensated by the doctor, who has been found to be negligent and deficient in her

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[615] SINGH &BHUSHAN supra note 123
[616] 1995(1)CPJ232
[617] Shubhanshu Bhattacharya v. B.S.Hegde 1993(3)CPR 414(NCDRC)
[618] *Rs.22-lakh compensation ordered for careless surgery*, THE HINDU, Thiruvananthapuram (23 March 2013). http://www.thehindu.com/todays-paper/tp-national/tp-kerala/rs22lakh-compensation-ordered-for-careless-surgery/article4540863.ece Last visited on 2-02-08-2016 at 16.48

medical service. And the hospital is vicariously liable for the acts of its staff and hence liable to pay compensation.

In *Vishwanath Birajdar v. Gangadhar Mitkari*[619], the hospital and the doctor were not negligent in performing the surgery. However taking services of unqualified compounder was held to be deficiency of service.

In another case[620], the doctor was held negligent in conducting surgery .As a result of which her duodenum got punctured and a second surgery had to be performed. Similarly negligence was proved in over administration of anaesthetic drug resulting in the patient going to vegetative state[621] Doctor has a legal duty to comply with applicable ethical and legal regulations in their daily practice. Ignorance of law and its implications will be detrimental to doctor, even though, he treats in good faith.[622] In a case of abdominal hysterectomy,[623] an injury was caused to the bladder resulting in two successive operations. The national Commission held that the surgeon should have been more vigilant during separation and dissection of bladder.

In an extreme case [624] of professional misconduct, digital evacuation – necessarily an allopathic procedure was performed by an Ayurveda doctor causing intestinal injury to the patient. The National Commission observed that digital evacuation is not a method for complete evacuation of products of conception. Looking at the nature of damage to the intestine, no further proof is required.*Res ipsa loquitur* was applied to hold the medical practitioner liable. In another case of complication and abdominal discomfort after the surgery, the operation was performed during the time when the patient was suffering from typhoid fever. It was observed by the National Commission that, "it is very important for treating doctor to properly document the management of patient under his care."[625]

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[619] II (2014)CPJ 184 (NC)
[620] Ritu Gupta v. Rajdhani Hospital III(2014) CPJ 528 (NC)
[621] G.Rajendra v. City Hospital and others III(2014) CPJ 598 (NC)
[622] V.K.Mehta v. Vimla Devi II (2014)CPJ 212(NC)
[623] Stefeena v. Lilly Joseph I (2015)203 (NC)
[624] Chitrangini Mujmule v..Manoj Jain I(2015) CPJ 51(NC)
[625] N.J. Karnavat v.Patel Iswarlal Mangalal I(2015) CPJ161(NC)

In *Rashmi Taryon's* case,[626] a thermal injury was inflicted during renal transplant and dry gangrene developed. It was held that even though the renal transplant was done with consent and according to the established medical procedure, patient lost his four fingers due to the the negligence of the hospital staff. They were made liable applying the principle of *res ipsa loquitur*. In *Ms Shefali Bhargavas case,*[627] a 17 year old girl was admitted to the hospital with complaint of fever and she was subjected to blood test which had shown a reduction in platelet count. Platelets were transfused to her. After the blood transfusion her blood was tested for HCV (Hepatitis C), antibodies and HB antigens which were found to be negative. She was discharged from the hospital with the advice that she should continue using the prescribed anti-malarial drug. Three months thereafter her SGBT (liver enzyme test) had shown abnormal result and the tests conducted revealed that she got an acute attack of hepatitis C infection. The National Commission elaborately dealt with the aspect of the patient contracting infection subsequent to the platelet blood transfusion at the hospital and held that failure of the hospital to produce the medical record would be a circumstance for an inference to be drawn against the hospital as they failed to produce medical record of the donors medical record to show their healthy back ground. The National Commission held that the circumstances of this case clearly show that the complainant must have got the Hepatitis C infection through contaminated blood.

4.2.7 POST-OPERATIVE CARE

It is the duty of the surgeon to ensure full recovery and rehabilitation. Post-operative care plays a major role in this.

In *John Andred's Case*,[628]complainant aged 67 years underwent coronary artery bypass grafting. During the post-operative period he developed severe lung infection. Though some anti biotics were prescribed by the doctor, it did not subside the infection. He had undergone another operation for removal of wires,

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[626] Rashmi Taryon v.Noida Medicare centre I(2016) CPJ 228 ()NC
[627] ShefaliBhargava v. Indraprstha Appollo Hospital I(2003)CPJ 216(NC).
[628] John Andred v. P.B. Hinduja National Hospital and Medical Research Centre, 1998 (1) CPR 579

which got infected. It was found that the casual approach of the doctor in treating the post-operative infection is amounting to deficiency in service. The Maharashtra State Commission held the hospital liable for the death of a patient owing to the continuous bleeding from the operational wounds.[629] The same forum held doctor guilty for falling below the required standard of care in leaving the patient in pain ignoring the post-operative care.[630]

In a case where the patient was operated for abdominal pain .Sutures were removed on the sixth day. But due to cough patient suffered abdominal burst leading to infection and death. It was held to be deficiency in post- operative care[631].Deficiency was proved in the sub- standard post -operative treatment which resulted in complicating the situation and necessitating multiple operations [632] Not complying with the very high standards of critical care required in the ICCU is clearly deficiency in service[633].Similarly surgeon is required to give and the hospital should provide along with discharge certificate, the instructions for post-operative care[634].

Ganta Mohan Lakshmi v. Dr. C.V.Ratnam and Anr[635] was a case of thombrosis (obstruction to the supply of blood) which is slow process. The patient was in the hospital for nearly a month, during the time the gangrene (a result of thrombosis) was set in and reached a stage which was incurable. The State commission held that this is a case of gross negligence during post-operative care.

Sathy M. Pillai's case,[636] the deceased was brought to the hospital for making sutures at the mouth of uterus to retain the pregnancy and prevent miscarriage.Patient died in the same hospital within 24 hours of the procedure. The National Commission found that, there was poor post-operative care. In

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[629] Arvindlal Shah v. Bombay Hospital Trust, 1992(2) CPR 154(Maharashtra)
[630] Alto Hussain Farocyjui v. Ashok Mathur 1998 (1) CPR 427
[631] Suyash Hospital v.Prasanna Kumar Ojha, 2003 CTJ708 (NC)
[632] A.K.S. Allana v. Saptarshi Medical and Research centre, 2000(3)CPJ 258 (Maharashtra)
[633] Bhajan lal Gupta v. Moolchand Kharati Ram Hospital. 2001 (1) CPJ 31(NC)
[634] N.K.Kohli v. Bajaj Nursing Home, 2000 (2) CPJ 308 (MP)
[635] 2002 (2)CPJ 144
[636] *Negligent doctors asked to cough up 3 lakhs for death of the patient.* MedIndia Network for Health,MedIndia General Health News (Last visited on 02-08-2016 at 17.23).http://www.medindia.net/news/view_news_main.asp?x=197. (undated)

M.C.Katares case,[637] the National Commission held that the hospital failed to maintain the record of diagnosis and treatment in accordance with the direction of the Supreme Court and the surgeon failed to exercise due care and diligence as also that there was failure on the part of the hospital and attending doctors to consult cardiologist at the time it was imminently required to provide a bed for patient in ICU six hours after her highly problematic surgery.

A.K.Mittal's case[638] is one where a child suffering from ear infection was admitted and operated upon. Thereafter, he developed facial paralysis and was discharged from the hospital. In the complaint filed by the patient through his father, the hospital was held negligent for its failure to furnish hospital records to the complainant to enable him to present the records to AIIMS where he was subsequently treated. The National Commission held that not furnishing the crucial records i.e., discharge summary before the District Forum, State Commission and before the National Commission would amount to deficiency in service.

Ram Gopal Varshney[639] is a case where the patient's eye was operated upon and his vision was lost. The complainant contended that there was lack of hygiene in the hospital. The National Commission held that the complainant failed to prove negligence on the part of the hospital or the doctor as there was no post-operative infection developed. In *K. A. Bhandula & Another v Indraprastha Apollo Hospital & Others,*[640] the National Commission partly allowed the complaint holding that the hospital was negligent in not duly preserving the biopsy tissue sample (in formalin).Commission rejected the hospital's plea of mere 'human error'. Further, the consultant doctor failed to advise the complainant to undergo a repeat biopsy at the earliest and instead recorded that there was no evidence of recurrence (of the disease). There was delay in conducting the second biopsy which led to delay in starting proper treatment while the cancer progressed. The Commission found that the surgery finally

[637] M.C.Katare v. Bombay Hospital and Medical Research Centre 2010(5) ALD (Cons) 1 NC.
[638] A.K.Mittal v. Raj Kumar 2009(5) ALD (Cons) 1 NC.
[639] Ram Gopal Varshey v. Lasor Sight India pvt ltd (2009)CPJ 23(NC).
[640] III (2009) CPJ 164 (NC)

recommended by the doctor was 'craniofacial resection' and observed that prima facie this surgery was (perhaps) not called for in the present case.[641] It was held that the doctor did not apply the due standards, expected of a surgeon of ordinary skills, in disclosing the necessity, implications and alternatives of treatment.

In *Dhanwanti Kaur's* case[642] surgery was performed by adopting laparoscopic procedure and without obtaining the consent of the complainant's husband opted for open cholecystectomy. The National Commission held that the opposite party failed to exercise requisite care and attention during postoperative stage.

In *Narangiben S.Shah v. Gujrat Research and Medical Institute and others*,[643]deficiency in service and violation of medical ethics was alleged against the action of doctors in prescribing and conducting angiography and by-pass surgery.The National commission held that the doctors have followed most desirable and expected course of action and if in the process patient has died, they cannot be held liable .The commission observed, " after all doctors can only treat, hay cannot guarantee success of a surgical operation which inevitably is fraught with risk."

In *Suresh Nanda v. Anup Kumar*,[644] patient died due to cardiac arrest .There was alleged deficiency in service of open cholecystectomy. The National Commission found that the respondent failed to make pre-operative assessment. Medical records were not maintained. Even the ECG report of the patient was not available for evidence. Not consulting a cardiologist to manage critical health of patient is a gross negligence. The commission observed that the conduct of the doctor is unethical and not expected from a professional who undertakes performance of such a delicate task.

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[641] *Consumer Advocate*,Newsletter On Consumer Affairs ,Limited Circulation Volume 2 (OCTOBER 2009) (Last visited on 25-08-2016 at 19.58). http://ncdrc.nic.in/Consumer%20Advocate2.pdf.

[642] Dhanwanti Kaur v. S.K.Jhujhunwala(Sr) 2010(6) ALD 19(NC)

[643] III (2012)CPJ 509 (NC)

[644] II (2012) CPJ 228(NC)

In *C.K.Pandian v. S.R.Trust and others*[645],the open surgery was performed for removing stone from gall bladder .Consent was taken only for laproscopy.The National Commission found that the respondents could not satisfactorily explain the reason for opting for an open surgery. It was held that the action of the respondent is contradiction to the medical literature and therefore held to be deficiency in service.

In *Beena Gard v. Kailash Nursing Home,*[646] the complainant developed a utero-vesical fistula(UVF),six months after C-section. It was alleged that the UVF is due to the negligence of the doctors. However she did not produce evidence to show link between surgery and development of fistula. Expert opinion proved that UVF can occur due to repeated C-sections. The complainant contended that the principle of *res ipsa loquitur* be applied. The Commission negated the contention. It is said that the *res ipsa loquitur* does not apply if the cause of the harm is known.

> This is a dark saying; the application of the principle nearly always pre-supposes that some part of the casual process is known. But what is lacking is the evidence of its connection with the defendants act or omission. When the fact of control is used to justify inference that defendant's negligence was responsible, it must of course be shown that the thing in his control in fact caused the harm. In a sense, therefore, the cause of the harm must be known before the maxim can apply.

In *Kasturba Medical College Hospital v. Ruma kumar*, [647] the complainant underwent surgeries in three occasions. All pre-operative assessments were adequate and proper. However complainant did contract staphylococcus infection while recuperating from surgery and it persisted despite treatment in the hospital. The commission held that there was limited deficiency in respect of post- operative treatment. In *Sunil Bhandari v. Puja Kori*[648], doctor's non-availability for services post-surgery without written instructions was held to be negligence. In case of a family planning operation, a post-operative complication was developed resulting in perforation in patient's uterus as well

[645] IV (2013)CPJ 496 (NC)
[646] (2002)IIICPJ 99 (NC)
[647] II(2013)CPJ 528(NC)
[648] III (2013) CPJ 142(NC)

as in her intestine. The surgeon was held liable[649]. The National Commission held in a case of death of patient due to multiple subcutaneous haemorrhages in abdomen, that:

> the doctor is not negligent in treating the patient only on account of her having developed haematoma and pseudoaneurysm.Doctor committed negligence in treatment of patient by not checking her anti- coagulation time and other parameters on regular basis and also by discharging the patient despite the fact that blood was still oozing from venous sheath at time of her discharge.[650]

In *Dr.L.K.Nepalia v.Kamla &Anr,*[651] taking follow up treatment after cataract surgery in a casual manner was held to be deficiency in service on the part of the surgeon. In another case Uttar Pradesh State Commission held that it is negligence on the part of the doctor which resulted post –operative complications and damage of two kidneys after a uterus surgery.[652]

4.3 PRODUCT LIABILITY AND MEDICAL NEGLIGENCE

Liability towards prescription drugs and medical devices involve a special area of the law known as product liability. In 1916, the landmark case of *MacPherson v. Buick Motor Co*. [653]made clear that manufacturers of defective products are liable for foreseeable injuries caused by their negligence. In other words, manufacturers are responsible for protecting consumers by making their products reasonably safe. In this case, the petitioner bought a car from a retail dealer and while using it got injured in an accident. Suit was filed against the defendant, the manufacturer of the Car. The accident was due to a faulty wheel, which was purchased by the manufacturer from another manufacturer. It was held that, the product is potentially dangerous if negligently made and the

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[649] Kalpana v. Dr.Kamalakshi & Anr. I(2015) CPJ 79(NC)
[650] Convenient Hospitals Ltd. v. Shankar Lal & Ors I (2015) CPJ 134(NC)
[651] I(2016) CPJ 302(NC)
[652] Sona Singh v. Nazareth Hospital I(2016) CPJ 73 (UP)
[653] 217 N.Y. 382, 111 N.E. 1050 **(**1916**).**See https://www.law.berkeley.edu/files/MacPherson_2d_Op.pdf Last visited 0208-2016 at 17.55.See also http://www.casebriefs.com/blog/law/torts/torts-keyed-to-prosser/duty-of-care/macpherson-v-buick-motor-co-2/ Last visited on 03-08-2016

product is known to be used by persons other than the original purchaser. Therefore the manufacturer has a duty to take care[654].

Later, *Donoghue v. Stevenson*[655] clarified the position by establishing that manufacturer owes a duty of care to the ultimate consumer of his product. The law requires manufacturers to adequately test their products' safety before they hit the market. It is also a requirement to warn the public of any risks associated with a particular drug or device. Drug makers and device manufactures are liable otherwise[656].This duty will also apply to those professional persons whose expertise is used to design or test these products.[657]

In *Bachan v.Ortho Pharmasuiticals (Canada) Ltd.Robins*[658],it was held that "….manufacturer of drugs like manufacturer of other products has duty to provide consumers with adequate warning of the potentially harmful side effects that the manufacturer knows or has reason to know may be produced by the drug….In the case of prescription drugs the duty of the manufacturer to warn consumers is discharged if the manufacturer provides prescribing physicians, rather than consumers with adequate warning of the potential danger"

In *Common Cause v. Drug Controller of India*[659], public interest litigation was filed by 'Common cause' regarding manufacturing defects in intravenous (IV) fluids. The National Commission issued directions to the Drug Controller of India, on the basis of which an expert committee was constituted. The committee submitted its report containing recommendations to protect the public from contamination of IV fluids which is sold through chemists or supplied through hospitals.In *Jagdeep Kakadia v. Ophthalmic and Drugs*

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655 [1932] AC 562 HL
656 *It's no surprise that product liability lawsuits are often necessary*. Drug watch, Drug and Medical Device Law Suits(August 20,2015).(Last visited on 30-08-2016 at 18.46). http://www.drugwatch.com/drug-lawsuits.php
657 *Id*
658 (1986)25 D.L.R. (4th)658,669 See SINGH &BHUSHAN supra note 123
659 1991(2)CPJ 698

India,[660] manufacturers of an eye drop 'Irrisol' was held liable for causing many patients lose their eyesight[661].

4.4 LAW IN UK

Law relating to Consumer protection in UK was spread over a number of legislation till recently, such as, Consumer Protection from Unfair Trading Regulations 2008 (CPRs), Consumer Credit Act 1974 Estate Agents Act 1979, Unfair Terms in Consumer Contracts Regulations 1999, Sale of Goods Act 1979, Supply of Goods and Services Act 1982, and Consumer Protection (Distance Selling) Regulations 2000.[662] Responsibility for UK consumer law enforcement, therefore was split between Trading Standards (local/regional enforcement funded by Local Authorities and BIS) and the OFT (Office of Fair Trading).[663]There are various sources of law applicable to consumer contracts for services. Some rules are found in legislations, i.e., Supply of Goods and Services Act 1982, Unfair Contract Terms Act 1977.Others are found in judge-made common law. In relation to services, consumers have certain legal rights.

In England and Wales general statutory rights related to contracts for providing services are set out in the Supply of Goods and Services Act 1982 (SGSA).(This legislation is not extended to Scotland).These rights are called 'implied terms' since they are implied into the contract even though they might not have been expressly. The implied terms are,

- That the service be provided with reasonable care and skill (Section13)

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[660] 1997(3)CPR229(Guj SCRDC)
[661] SINGH &BHUSHAN supra note 123
[662] *Consumer Law and Business Practice,Drivers of compliance and non-compliance,* OFFT1225 ,Office of Fair Trading, (June 2010). http://webarchive.nationalarchives.gov.uk/20140402142426/http:/www.oft.gov.uk/shared_oft/reports/Evaluating-OFTs-work/OFT1225.pdf. Last visited on 30-08-2016 at 19.12
[663] *Empowering and Protecting Consumers, Consumer Landscape Review: Impact assessment on enforcement, advocacy and Information, advice and education, Department* of Business Innovation and Skill (April 2012). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253725/bis-12-637-empowering-protecting-consumers-impact-assessments.pdf. Last visited on 30-08-2016 at 19.18

- That where there is no agreed time for performance of the service the business carries out the service within a reasonable time (Section.14)
- That where there is no price agreed the consumer will pay a reasonable amount for performance of the service (Section.15)

Consumer rights in Scotland derive from the Scottish Common Law (Scottish judge-made case law).The rights are similar but not identically expressed to those found in the SGSA Consumers have other rights in sector specific legislations. Remedies derive from the judge-made principles of common-law of contract .These principles are continually being refined by the courts.[664]

No statutory redress regime was available in the services sector. There was no clarity on what consumers are entitled to get, by way of redress. It brought a difficult situation.[665]Definite principle is absent to redress violation of consumer rights. They are not enunciated in any of legislation in UK jurisdictions.Consumer service law particularly was made difficult to understand. It caused confusion among businesses and consumers. The remedies available might include money back from the business to compensate the consumer, or re -performance of the service or a part of it.[666] However, the extent of remedy depends on a number of factors, which applies differently in each individual scenario. These rights and remedies will not apply, or will only apply to a limited extent, often.[667]

A report in 2008 by the University of East Anglia to benchmark the UK's consumer empowerment regime found that the UK regime fared well overall but identified uneven enforcement as a key weakness, alongside overly-complex legislation.[668]As far as consumer rights are concerned this report found

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[664] *Consumer Rights Bill, Revised Impact Assessment: Final,*Department of Business Innovation and Skill((January 2014). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/274823/bis-13-1361-consumer-rights-bill-proposals-on-services-impact-final.pdf . Last visited on 30-08-2016 at 19.23

[665] *Id*

[666] supra note 664

[667] *Id*

[668] *Benchmarking the performance of the UK framework supporting consumer empowerment through comparison against relevant international comparator countries,* BERR(December 2008)

UK to be the best in comparison with Canada, US, Denmark, Australia, Germany and Spain. This study which focused on institutional dimensions of empowerment concluded that the UK has scope for improvement and identified redress mechanisms and public enforcement as key areas which need attention. Investment in information and advice services was seen as an important development[669]

The Consumer Rights Act 2015 (CRA 2015) came into force on 1 October 2015.The Act is a great leap in Consumer law in UK, over the last few years. It brings structural changes to consumer law enforcement bodies. The declared objective is to consolidate consumer rights into one place. It envisions to enhance consumer protections and to modernise the law to take into account digital advances [670]. To empower consumers by creating a simplified and enhanced legal regime that confirms better situation for consumers of goods, services and digital content[671].

This Act is replacing three major consumer legislation, i.e., Sale of Goods Act 1979, Supply of Goods and Services Act 1982 and Unfair Terms in Consumer Contracts Regulations 1999.[672]. CRA 2015 as per its design reform consumer rights in this respect. It empowers consumers and small and medium enterprises (SMEs) to challenge anti-competitive behaviour through the Competition Appeal Tribunal (CAT).It consolidates provisions regarding enforcement agencies and their jurisdiction. The Act applies to contracts and consumer notices between a trader and a consumer.[673]

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http://webarchive.nationalarchives.gov.uk/20121212135622/http://www.bis.gov.uk/files/file50027.pdf .Last visited on 30-08-2016 at 19.27

[669] *Empowering consumers*, Background paper 1: possibilities and limitations (January 2013). Legal services ConsumerPanel. http://www.legalservicesconsumerpanel.org.uk/publications/research_and_reports/documents/ChoosingUsingBP1.pdf. Last visited on 30-08-2016 at 19.31

[670] Lorraine Conway ,*Consumers*, Commons Briefing papers SN06588 1-4 (13 July 2015) http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06588 . Last visited on 30-08-2016 at 19.35

[671] Lorraine Conway supra note 670

[672] *Consumer Rights Act,2015*,Which?,Consumer Rights(2016). http://www.which.co.uk/consumer-rights/regulation/consumer-rights-act. Last visited on 30-08-2016 at 19.40

[673] Lorraine Conway supra note 670

The Act is in three parts and contains 10 Schedules:

- Part 1 deals with consumer contracts for goods, digital content and services;
- Part 2 covers unfair terms; and
- Part 3 contains miscellaneous and general provisions.

The special attraction is the provision in respect of effect of violation of Consumer Rights in service sector . The Act brings clarity in this regard.[674]Alongside these developments, a new EU Consumer Rights Directive (2011/83/EU), adopted in October 2011, had to be implemented in UK. Most of the requirements of the Directive have now been implemented through the Consumer Contracts (Information, Cancellation and Additional Payments) Regulations 2013, which came into force on 13 June 2014. In addition, the Consumer Protection (Amendment) Regulations 2014 amend the Consumer Protection from Unfair Trading Regulations 2008. These Regulations provide consumers with rights to redress in respect of misleading and aggressive commercial practices by traders. These changes came into force on 1 October 2014 and apply to contracts entered into, or payments made, on or after that date. The CRA 2015 aims to stand alongside regulations to set out basic rules and create a body of consumer law in UK. [675]

The majority of the healthcare provisions in the UK are under the state-run National Health Service (NHS). While funded centrally from national taxation, NHS services in England, Northern Ireland, Scotland, and Wales are managed separately. The focus of medical liability in England and Wales is under the law of tort, specifically negligence. It is based on a government policy known as NHS indemnification. That means the NHS trust is vicariously liable for the negligent act of its employees-including doctors, nurses and clinicians.[676]

This has major consequences that when compensation and legal costs are payable as a result of medical malpractice in the NHS, this money comes from

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[674] *Id*
[675] Lorraine Conway supra note 670
[676] *Medical Malpractice Liability: United Kingdom (England and Wales)*, The Law Library of Congress,Law.gov.(May 2009).https://www.loc.gov/law/help/medical-malpractice-liability/uk.php. Last visited on 17-08-2016

the taxpayer. There is great concern as to the increasing costs to the public purse of clinical negligence claims[677]. This concern had been present for several years but now, more than ever before, it has become the dominant issue in clinical negligence litigation[678].

A small percentage of UK medical malpractice laws deal with cases arising from the relatively small percentage of citizens relying upon the more expensive private sector healthcare market.[679] Most of the private clinical negligence claims will be subject to the terms of the contract between the patient and provider. Most case-specific contracts outline specific procedures with reasonable standards of care defined by the law and medical experts.[680]

4.5 LAW IN USA

The modern consumer protection movement in United States began in the 1960s which was spearheaded by the Consumer Bill of Rights by President Kennedy.[681] John F. Kennedy recognised that consumers are the largest economic group in the country's economy, affecting and affected by almost every public and private economic decision. And they are also an important group, not effectively organised, and whose views are not heard. Kennedy had equated the rights of the ordinary American consumer with national interest. He gave the consumer four basic rights[682].

- The Right to Safety - to be protected against the marketing of goods which are hazardous to health or life.
- The Right to Choose - to be assured, wherever possible, access to a variety of products and services at competitive prices: and in those industries where

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[677] *Id*
[678] Richard Goldberg, *Medical Malpractice and Compensation in the UK*, 87 Chi.-Kent. L. Rev. 131 (2012).
[679] *State Medical Malpractice Laws Explained Briefly* Medical Law Centre,State Medical Practice Laws .(Last visited on 17-08-2016 at 12.36)http://www.malpracticecenter.com/states/uk.(Undated)
[680] *Id*
[681] Waller et al., *Consumer Protection in the United States: An Overview* , http://www.luc.edu/media/lucedu/law/centers/antitrust/pdfs/publications/workingpapers/USConsumerProtectionFormatted.pdf. Last visited on 30-08-2016 at 19.55
[682] Waller et al.,supra note 681

competition is not workable and Government regulation is substituted, an assurance of satisfactory quality and service at fair prices.

- The Right to Information - to be protected against fraudulent, deceitful or grossly misleading information, advertising, labelling, or other practices and to be given the facts s/he needs to make an informed choice.
- The Right to be heard - to be assured that consumer interests will receive full and sympathetic consideration in the formulation of Government policy, and fair and expeditious treatment in its administrative tribunals.[683]

Later President Gerald Ford felt that these four rights were inadequate for a situation where most consumers are not educated enough to make the right choices. So he added the Right to Consumer Education, as an informed consumer cannot be exploited easily.[684] In 1914, the U.S. Congress passed legislation creating the Federal Trade Commission (FTC), as a primary effort in fighting abusive and anti-competitive business practices. [685]It is the principal, consumer protection agency at the federal level in the United States.[686]It derives its consumer protection authority primarily from Section 5(a) of the FTC Act, which prohibits "unfair or deceptive acts or practices in or affecting commerce.[687]

According to the FTC, deception occurs when there is a material representation, omission, or practice that is likely to mislead a consumer who is acting reasonably under the circumstances. Unfair practices are those which cause, or are likely to cause, reasonably unavoidable and substantial injury to consumers without any offsetting countervailing benefits to consumers or competition. [688] The FTC enforces most federal consumer laws, through

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[683] Waller et al., supra note 681

[684] *Consumer Rights and Its Expansion*, CUTS International,CUTS Centre for Consumer Action Research and Training(1999).(Last visited on 30-08-2016 at 20.16). http://www.cuts-international.org/consumer-rights.htm.

[685] *What is Consumer Rights Law*? H.G.org.Legal Resources, Consumer Rights -Consumer Protection Law.(Last visited on 30-08-2016 at 20.13)). https://www.hg.org/consume.html (Undated)

[686] Waller et.al.,supra note 681

[687] *Id*

[688] Waller et.al.,supra note 681

administrative proceedings, lawsuits or its rulemaking power. Often, it takes action on complaints about products, services or businesses.[689]

In 1997,the Advisory Commission on Consumer Protection and Quality in the Health Care Industry was appointed to "advise the President on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system"[690].In 1998, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry issued its final report, which included the Consumer Bill of Rights and Responsibilities.[691]The bill of rights aims to achieve the following objectives.

- To strengthen consumer confidence by assuring the health care system is fair and responsive to consumers' needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and assuring their health.
- To reaffirm the importance of a strong relationship between patients and their health care professionals.
- To reaffirm the critical role consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status.[692]

In the United States, patients have received more protection than other consumers, since the patients' rights movement in 1970s.[693]Patients are entitled

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[689] *Consumer Protection Laws, Lawyers.comConsumer Fraud* (2016).(Last visited on 30-08-2016 at 20.27) http://consumer-law.lawyers.com/consumer-fraud/consumer-protection-laws.html

[690] *Consumer Bill of Rights and Responsibilities*, AHRQ,Agency for Healthcare Research and Quality, Executive Summary, Appendix A,President's Advisory Commission on Consumer Protection in the Health Care Industry, US Department of Health and Human Services.(Last visited on 30-08-2016 at 20.34) *http://archive.ahrq.gov/hcqual/final/append_a.html* (undated)

[691] *Consumer rights and responsibilities*, US National Library of Medicine, Medicine plus (14-08-2015)(Last visited on 30-08-2016 at 20.38). https://www.nlm.nih.gov/medlineplus/ency/article/001947.htm

[692] supra note 690

[693] Aniket Agrawal&Arunabha Banerjee, *Free Medical Care And Consumer Protection*, Vol 8, No 4 (2011) .Indian Journal of Medical Ethics. http://www.issuesinmedicalethics.org/index.php/ijme/article/view/267/465 .Last visited on 25-08-2016 at 12.10

to all the information in their medical records because the information belongs to them[694].The Courts have recognized right to emergency care[695].There are legislations requiring hospitals with emergency departments regardless of insurance coverage or the ability to pay[696]. This is a universal right in the country.[697]

Since1980s a transition is seen in favour of managed care organisations from a fee-based service where even the recipients of free medical care get their rights converted into those of private enforcement.[698]A new form of health plan known as the social/health maintenance organization (S/HMO) was experimented which combines Medicare HMO coverage of hospital and physician services with chronic care benefits (e.g., nursing home, personal care, homemaker services) and other expanded benefits (e.g., prescription drugs, eyeglasses, and dental care)[699].The earlier fiduciary relationship was shifted to a contractual obligation wherein the poorer sections can assert themselves as consumers even more[700] .The following are recognized as the Health Care Consumer Rights[701]

- Information Disclosure**:-**It is the right to receive accurate information about your health, treatments, health plan, providers, and health care facilities.
- Choice of Providers and Plans:-It is the right to choose health care provider, within your health plan.
- Access to Emergency Services:-The right to get emergency services whenever and wherever needed, to be seen by a doctor and get services.

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[694] Yarmolinsky A. *Supporting the patient*. *New Engl J Med.* 602-03,332(9) (March 2,1995).
[695] *Manlove v. Wilmington Gen. Hosp.,* 174 A.2d 135 (1961).
[696]Amy J. McKitrick ,*The Effect of State Medical Malpractice Caps on Damages Awarded under the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd)171-197,* 42 Clev. St. L. Rev. (1994).
[697] *Estelle v. Gamble*, 429 US 97 (1976).
[698] Agrawal & Banerjee supra note 693
[699] Newcomer et al., *Social Health Maintenance Organizations: Assessing Their Initial Experience,* HSR: Health Services Research 425-454, 25:3 (August 1990). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1065638/pdf/hsresearch00079-0008.pdf. Last visited on 25-08-2016 at 12.35
[700] Agrawal& Banerjee supra note 693
[701] supra note 691

- Participation in Treatment Decisions:-Right to get information about all the treatment options. And right to make decisions about one's own care. Parents, guardians, family members, or others can participate, if patient cannot make his own decisions.
- Respect and Non-discrimination:-Right to get considerate and respectful care. Includes right not be discriminated against by doctors, other health care providers, or health plan representatives.
- Confidentiality of Health Information:-Right to privacy in dealings with provider. Right to have health care information protected. There is a right to review and copy your own medical record also.
- Complaints and Appeals:-Right to get a fair, expedite, and unbiased review of any complaint against health plan, doctors, hospitals, or other health care personnel.

4.5.1 CONSUMER CLASS ACTION

Class actions are very powerful tools in the hands of consumer **.**USA is one of the countries that has fully exploited the power of this method. Class actions are characterised as non-traditional form of litigation in *United States Parole Comm'n v. Geraghty.*[702]Unlike litigations pursued by an individual, in a class action, the decision to settle or dismiss the case will require court's permission. Class actions are also reported to have better impact on the defendant.[703] As normally the fight is between a mighty business house and a meek individual, even if they have to pay compensation, it is meagre compared to the corporate financial strength. But when it comes to class actions, the company may take more seriously, the threat of a class wide judgment. A class action may have a consequential effect in modifying the policies of other companies doing similar practices.[704] It was observed that "…in a large and impersonal society, class actions are often the last barricade of consumer protection…."[705]

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[702] 445US 388,402,100 S.Ct 1202, 1212, 63.L.Ed. 2d 479 (1980)
[703] JUSTICE D.P.WADHWA& N.L.RAJAH ,THE LAW OF CONSUMER PROTECTION 1504-1508 (2nd ed.2009)
[704] *.Id*
[705] Eshaghi v. Hanley Dawson Cadillac Co. 62 III App.3d 995,574 N.E.2d. 760(1991)

4.6 CONSUMER PROTECTION IN INDIA : CURRENT SCENARIO

The highly commercialised private sector accounts for a substantial proportion of health care in India (50% of inpatient care and 60-70% of outpatient care), but has received relatively less attention from the policy makers as compared to the public sector.[706] Therefore the private sector health care delivery system in India has over a period of time established themselves as uncontrolled authorities. The competency of private medical practitioners in India is highly questionable.[707] Various studies suggest that the technical quality of care provided by them is inadequate. It was also observed that the competence necessary to recognize and handle medical conditions is quite low and the private health care providers visited by the poor are less capable for their job than those visited by the rich.[708] There are myriads of cases reported with clear evidence of serious deficiencies in services. Problems range from inadequate and inappropriate treatments, excessive use of higher technologies, to serious problems of medical malpractice and negligence.[709]

Consumer Protection Act indeed provides an easily accessible economic remedy against such practices. However, protection is made intricate by other socio-political factors influencing exercise of consumer rights. There is a vast disparity of awareness regarding consumer rights in different regions in the country. It is very poor especially among the population in rural areas.In our country, substantial number of the rural people lives below the poverty line and we have high level of unemployment and poor literacy level.[710] It is not surprising that consumer awareness in India is much lower in comparison with

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[706] Report on the Working Group on Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure
For the 11th Five-Year Plan ,Government of India Planning Commission.
http://planningcommission.nic.in/aboutus/committee/wrkgrp11/wg11_hclinic.pdf Last visited on04-08-2016 at 14.56

[707] P. H. Rao, *The Private Health Sector in India: A Framework for Improving the Quality of Care,* ASCI Journal of Management14–39 (41 (2)(March 2012).
http://asci.org.in/journal/Vol.41(2011-12)/41_2_phrao.pdf Last visited on 04-08-2016 at 16.55

[708] P. H. Rao, *Id*

[709] *Id*

[710] Suresh Misra& Sapna Chaddah, *Consumer Awareness in Rural India - An Empirical Study* Centre for Consumer Studies Indian Institute of Public Administration (2009).
http://www.iipa.org.in/sapna.html. Last visited on 30-08-2016 at 21.00

that of developed countries. There are many reasons, economic inequality; low levels of literacy, ignorance, lack of exposure are some among that. Consumers are not able to assert their rights, on many occasions leading to continuous exploitation.[711]

Though the overall disposal rate and the performance of the Consumer Fora is considered to be impressive, still, the delay in disposal of cases by the redressal agencies at the District, State and National level and the number of pending cases has been a cause of major concern. The Act was amended in the years 1991, 1993 and 2002. As a sequel to the amendment in the Act, Consumer Protection Rules were amended, new provisions introduced wherever it was considered necessary. Similarly, the Consumer Protection Regulations, 2005 was notified by the NCDRC after getting the approval of the Central Government to supplement the Rules in order to provide a uniform procedure for day to day functioning of the Consumer Fora.[712]

Efficient functioning of Consumer Forum can be judged by considering the disposal of complaints within the stipulated time frame of 90 days and 120 days. In this regard the time frame has hardly been strictly adhered to. In fact, only 19 per cent of over all cases at State Commissions, 9 per cent at District Forums Urban and 21 per cent at District Forum were disposed within the stipulated time[713]. Complaints are not being filed in relation to unfair trade practices, restrictive trade practices, hazardous goods/services, misleading advertisements. As a result the reliefs provided and introduced by the Third amendment in relation to the above are not utilized. In these areas the role of governments and NGOs / VCOs is of prime importance particularly in absence of *suo moto* power to the Commissions / Forum.[714]

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[711] Report Of The Working Group On Consumer Protection15-16 Twelth Plan (2012-17) Volume - Ii Subgroup Report Government Of India Department Of Consumer Affairs Ministry Of Consumer Affairs, Food And Public Distribution. Http://Planningcommission.Gov.In/Aboutus/Committee/Wrkgrp12/Pp/Wg_Cp2.Pdf
[712] *Id*
[713] *Id*
[714] *Id*

A study on performance of District forums in Western Uttar Pradesh[715]suggest that, a huge backlog of pending cases is the major problem .In total registered cases, portion of pending cases is higher than portion of new registered cases. Speed of disposal is lesser than speed of new registered cases Snail speed of disposal is another concern because none of the Forum has been able to dispose of 50% of its registered cases. Significant difference is noticed amongst the performances of various dispute redressal bodies.

Consumer Fora were conceived, as a speedier and efficient alternative to civil courts. But experience shows that they are becoming another form of the latter.[716]According to the National Consumer Redressal Commission, only 46% of cases in the District Forum were settled in the mandated time and 38% of cases in the State Commission. Ministry of Consumer affairs, Food and Public Distribution, reports that there are 3, 50,000 cases pending.[717].

According to a study undertaken by IIPA in 5 States, third Amendment has not yet made any impact on the appearance of advocates. Analysis of data revealed that 85 per cent consumers preferred to engage advocates for their complaints, though the intention of the CPA is that the complainants could argue their case themselves in the consumer courts. It was also noted that in rural areas in all five states appearance by advocates is more prevalent. Reasons are mostly, illiteracy, lack of awareness and ignorance of courts' procedure.[718]

There is a lack of co-ordination between centre and states. The states complain about inadequacy of funds from centre. The centre maintains the stand that, even though the consumer affair is a state subject, funds are provided to states, but neither they use it well nor do they supplement with their own funds[719] Promotion of consumer awareness is essentially the responsibility of the

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[715] Yashpal Singh, *An Analysis Of Performance of District Consumer Forums in Western Uttar Pradesh.* http://www.ijmetonline.org/admin/articles/_1342960013.pdf .Last visited on 30-08-2016 at 21.04

[716] *Are Consumers Courts really serving the consumers*? The Economic Times,(April 12, 2011).(Last visited on 30-08-2016 at 21.06) . http://www.cuts-international.org/cart/media-Are_consumer_courts_really_serving_the_consumers.htm.

[717] *Id*

[718] supra note 711

[719] supra note 716

respective State governments. The expenditure on the National Commission is borne by the GOI while that on the State Commissions and District Forums is funded by the respective State governments. The GOI supplemented the State efforts by providing funds for the programmes aimed at strengthening of infrastructure and enhancing consumer awareness and rights. Apart from the above, the GOI had been releasing funds to the State governments and NGOs in supplementing the State government's efforts in promotion and protection of welfare of consumers and strengthening of voluntary consumer movement. It would be seen that the utilization was far below the funds available with the Ministry. The funds remained unutilized in the absence of any large scale programme to match with the inflow.[720]

The consumers apart from being unorganized do not have the mechanism to understand their rights and responsibilities. Studies reveal not only lack of awareness but lack of consumer education as well. The reluctance of consumers to make use of the redressal system is one of the major bottlenecks in Consumer Protection.[721]

Proposals to further amend the Act are under consideration. These amendments are aimed at: (a) Widening the scope and amplifying the provisions of the Act, (b) Facilitating quicker disposal of complaints and (c) Rationalising the qualifications and procedure of selection of President and Members of the Consumer Fora.[722]

4.7 CONCLUSION

COPRA has been in operation for almost 30 years. A number of deficiencies and shortcoming in respect of its operation have come to light thereby requiring amendments on three occasions, still leaving scope for further improvements.

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[720] CAG, Performance Audit of the Implementation of the Consumer Protection Act and Rules-Report of the Comptroller and Auditor General of India for the year ended March 2005, Union Government (Civil), Performance Audit,p.5 (2006) http://www.cag.gov.in/sites/default/files/old_reports/union/union_performance/2005_2006/Civil_%20Performance_Audits/Report_no_14/introduction.pdf Last visited on 30-08-2016 at21.13

[721] *Id*

[722] supra note 711

Despite all this it has stood the test of time and has been an effective tool in the hands of the consumers to ensure accountability of procedures of goods and providers of services .However the following points need immediate attention as its reach to settle medical negligence disputes is concerned.

Including 'medical services', within the meaning of 'service' under Consumer protection Act was a breakthrough in medical jurisprudence in India. Our Country has a distinct position among other legal systems for this unique mechanism of medical negligence redressal. However, Consumer Fora are not free from the flaws of civil courts with a more formal approach, inordinate delay and ubiquitous presence of advocates. These quasi-judicial bodies are still not what they are envisaged under the Act. One of the major hindrances in the consumer movement in the country is the lack of awareness among the consumers. Lack of enthusiasm on the part of state governments, inadequate funding, lack of infrastructure, insufficient human resources etc. are plaguing the system. Lack of coordination between centre and states in this respect is adding insult to the injury. The ground realities of Consumer Protection in India is not so good, it is worse when it comes to medical negligence, as the consumers in this case are more delicate and emotionally affected.

Since medical negligence cases are increasing day by day a separate mechanism in the model suggested by COPRA, exclusively to deal with medical services is urgent. Lacunas are to be filled. Particularly with respect to adducing evidences in medical cases, clarity in principles is required. More enthusiasm and better co-ordination is to be initiated in ensuring faster settlement of cases. Systemic flaws must be removed, to be precise, the paternalistic approach in medical care need to go both from the mind set of health care providers and judicial officers. Appropriate changes are to be brought in to establish a more effective redressal mechanism to protect the medical consumer in true sense.

CHAPTER V
REMEDIES

CHAPTER V REMEDIES

5.1 INTRODUCTION

In order to seek remedy for an adverse outcome from the medical practitioner, a patient may bring an action under various branches of civil law. It can be Tort, Contract, or Consumer law.[723] . A civil suit enables the victim to seek a remedy from the person who injured her. Unlike a criminal case, which is prosecuted by the state, it is initiated by the victim or the victim's estate. A successful suit is followed by a judgment of liability that requires the defendant to compensate the plaintiff financially[724]. In principle, an award of compensatory damages shifts all of the plaintiff's legally cognizable costs to the defendant. On rare occasions, a plaintiff may also be awarded punitive damages, which go beyond what is necessary for compensation[725].

5.2 LAW OF TORT AND COMPENSATION

Tort law occupies a significant place in private law. Due to historical and epistemological features of this legal system, it is included in the substantial corpus of civil law[726].There are various theories which explain the purpose of its very existence.

Analytical theories, basically aim to interpret and explain. The fundamental concepts of substantive norms and procedural features are identified to explain how they are related.[727] In this branch of law, the substantive norms are mainly the wrongs that tort recognizes and the remedies that it provides. One of the major procedural features is that tort suits are 'bilateral'. They are filed by the

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[723] Rachel Callinan, *Medical Negligence and Professional Indemnity Insurance*, Background Paper No 2/01, NSW PARLIAMENTARY LIBRARY RESEARCH SERVICE.Available at: https://www.parliament.nsw.gov.au/prod/parlment/publications.nsf/0/06606e8109509100ca256ecf000b1907/$File/bg02-01.pdf.Last accessed on 01-07-2016 at 17.47.

[724] Jules et al.,*Theories of the Common Law of Torts*, The Stanford Encyclopedia of Philosophy,Winter Edition(2015), Edward N. Zalta (ed.). http://plato.stanford.edu/entries/tort-theories/ .Last visited on 30-08-2016 at 22.46

[725] *Id*

[726] Ionuț Tudor, T*ort law from the perspective of corrective and distributive justice*, Journal of Public Administration, Finance and Law 171-175 Issue 7(2015).

[727] Jule et al supra note 724

victim rather than by the state.[728]Similarly, Normative theories seek to justify or reform and justificatory theories provide a normative grounding. These theories defend the values Tort law stands for and the goals it aims to achieve. Reformist theories, on the other hand seek to bring improvement in the law. It is achieved mainly, through recommending those changes that would bring the system closer to its core values.[729]There is no clear demarcation between analytical and normative theories. Analytical theories are closely related to fundamental normative concepts. And, normative theories are always at least partly analytical. Such theories, quite often seek to justify or reform the existing system.[730]

Traditionally, Tort law has two purposes. The first is to provide timely and reasonable compensation to those who are wrongfully injured and second to deter such wrongful conduct.[731] The purpose of compensation is to allocate the risk of losses. It is also to create the incentives for potential wrongdoers not to cause harm. Apart from this, the compensation has a purpose of distribution of income, in cases where the wrong doer and victim belong to groups having different levels of income.[732] The liability component is arrived at by following the philosophy of either corrective or distributive justice.

The concepts of distributive and corrective justice belong to Aristotle, who has coined the relation between parties as bipolarity. Justice according to him is affected by the direct transfer of resources from one party to another. It is as if there is a divided line between unequal parts and he takes what exceeds the half of the bigger segment and adds it to the smaller one. The resources represent the plaintiff's wrongful injury and the defendant's wrongful act.[733] As distinguished by Aristotle, corrective justice requires 'arithmetic' allocation and distributive justice 'geometric' allocation. While allocating, social and other

[728] Jules et al.,supra note 724
[729] *Id*
[730] *Id*
[731] Benjamin R. Civiletti, *Zeroing in on the Real Litigation Crisis: Irrational Justice, Needless Delays, Excessive Costs*, 46 Md. L. Rev. 40 (1986)
[732] Tudor supra note 726
[733] *Id*

factors come into consideration in the second case.[734]Corrective justice simply requires the reversal of wrongful changes to an initial distribution of resources. If the initial distribution of resources is not just then, it is distributive justice, which will help society maintain the equilibrium from a socialistic point of view.[735]

The justice concept retains that negligence law is an articulation of our ordinary moral concept of agency and responsibility, carelessness and wrongdoing, harm and reparation[736].The economic concept holds it as one which embodies an appropriate public morality. When it comes to preventing harm, by deterrence, the question is which harms we wish to deter, and how to deter them. Or else, if it is reparation, which injury we wish to compensate and how best to compensate for them[737] .When tort compensation is not limited to the redress of wrong conduct, the liability rule will necessarily serve two functions—it identifies the conditions under which injury compensation is desirable and accordingly creates financial incentives for duty holders to avoid injuring others by acting safely.[738]

The major battle in tort theory in the last three decades of the Twentieth Century was a battle between two ideologically opposed forces within the theoretical school of law and economics.[739] One side was represented by Richard Posner whose theory considers negligence to be the fundamental principle of tort law, which has the effect of reducing the liabilities of commercial actors to the amount necessary for them to internalize the costs of their activities, at the same time diminishing the capacity of the state to use tort law as a means of income

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[734] HANOCH SHEINMAN, *Tort Law and Distributive Justice in*,PHILOSOPHICAL FOUNDATIONS OF THE LAW OF TORT (John Oberdiek ed.2014)
[735] Jules et al.,supra note 724
[736] Gregory C. Keating, *Distributive and Corrective Justice In The Tort Law Of Accidents*, 74 So. Cal. Law Rev. 193 (2000)).
[737] Keating supra note 736
[738] Mark A. Geistfeld, New York University School Of Law ,Public Law & Legal Theory Research Paper Series Working Paper No. 13-38 Law & Economics Research Paper Series Working Paper No. 13-22 (July 2013) http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2293124. Last visited on 7-10-2016 at 15.28
[739] Benjamin C. Zipursky, *Richard Epstein and the Cold War in Torts* 3 Journal oTort Law 1 (2010).

redistribution, and smoothing the way for more unfettered market activity.[740] The other side was represented by Guido Calabresi whose cheapest-cost avoider based theory placed strict liability as the fundamental principle of tort law.[741]. Calabresi considers that the principal function of accident law is to reduce the sum of the costs of accidents and the costs of avoiding accidents. The goal is defined as finding the "cheapest cost avoider" and putting the legal responsibility on him.[742] Each person who infringes upon another's property Right is required by the law to compensate the property owner for the infringement, so each one who causes injury to another's body is also liable to the other for the costs of the injury inflicted.[743] The purpose of tort law is not to compensate or deter certain conducts, but to protect each person and his right against the infringements of others. [744] Invading the rights of another a wrongdoer upsets a pre-existing equilibrium between the parties. Liability is imposed upon him to re- establish that equilibrium and is for that reason required by justice.[745]It was explained in this way:

> But in a social sense it should be clear that people will act in a manner to minimize their losses, regardless of the legal rules adopted. Once people know that others are not obliged to assist them in their time of peril, they will on their own take steps to keep from being placed in a position where they will need assistance where none may be had. These precautions may not eliminate losses in the individual case, but they should reduce the number of cases in which such losses should occur"[746]

In *Rylands v. Fletcher*[747] the principle of liability was laid down that a the party who owns land and collects and keeps there anything likely to do harm is liable to compensate that damage, if such thing escapes and does damage to another. This rule applies only to non-natural user of the land and it does not apply in certain situations .That is, if those things are there naturally on the land or where

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[740] *Id*
[741] *Id*
[742] Richard A. Posner, *Guido Calabresi's 'The Costs of Accidents': A Reassessment*, 64 Maryland Law Review 12 (2005). http://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=2874&context=journal_articles. Last visited on 17-08-2016 at 9.03
[743] Hanoch Sheinman supra note 734.See also Richard A. Epstein, A theory of strict liability. 2 Journal of Legal Studies 203-204(1973).
[744] *Id*
[745] *Id*
[746] Richard A. Epstein, A theory of strict liability.2 Journal of Legal Studies 203 (1973).
[747] 1866 Law Report 1 Exchequer 265

the escape is due to an act of God. An act of a stranger or the fault of the person injured is exempted. If the thing which escapes are present by the consent of the person injured or in certain cases where there is statutory authority, it is excused[748].The Indian Supreme Court in *M.C. Mehta's*[749] case evolved new principle of liability called absolute liability. This is a stricter form of strict liability by which any person who is engaged in use of land which is inherently hazardous is absolutely liable to compensate the damages it causes. The Court observed:

> An enterprise which is engaged in a hazardous or inherently dangerous industry which poses a potential threat to the health and safety of the persons working in the factory and residing in the surrounding areas owes an absolute non-delegable duty to the community to ensure that if any harm results to anyone, the enterprise must be held to be under an obligation to provide that the hazardous or inherently dangerous activity must be conducted with the highest standards of safety and if any harm results on account of such activity the enterprise must be absolutely liable to compensate for such harm irrespective of the fact that the enterprise had taken all reasonable care and that the harm occurred without any negligence on its part.

The Court expressed that,

> The measure of compensation in such cases must be co-related to the magnitude and capacity of the enterprise because such compensation must have a deterrent effect. The larger and more prosperous the enterprise, the greater must be the amount of compensation payable by it for the harm caused on account of an accident in carrying on of the hazardous or inherently dangerous activity by the enterprise".

Thereby establishing that the purpose of compensation is not only compensatory, it is deterrence and vindictive too.

5.3 LIABILITY 'FAULT' AND 'STRICT'

In most Anglophone jurisdictions, compensation is paid through a court-based tort law system. The tort systems typically endorse the 'fault criterion' according to which the victim of an injury is awarded compensation, paid by

[748] M.C.Mehta v.Union of India 1988 AIR 1115
[749] *Id*

the injurer, only if it is established that the injurer in question was at fault.[750] In a second group of jurisdictions, including Sweden, Denmark, Norway, Finland, France, New Zealand, Florida and Virginia, the fault criterion has been eliminated, at least for some kinds of medical injury. These moves have been taken to their greatest extent in New Zealand, where a statutory accident compensation system has for over 30 years compensated medical injury on a no-fault basis[751].

Under a regime of fault liability, a person is liable for injuries he causes while failing to act as a reasonable person in the similar circumstances. It will not make anyone liable for injuries, causing which he is blameless. The difference between the two regimes of liability is that under fault liability you can avoid liability if you act as a reasonable person, whereas you will be liable subject to strict liability even if you had sufficient reason for what you did. [752] Justifications or reasonableness will not undermine strict liability.

The philosophical relevance of strict liability consists in accepting certain situation as special, in which a liability can arise, even in the absence of a faulty conduct.[753] Each of us accepts, in daily life, a degree of risk that we must tolerate in light of our own production of similar risks to others. When people do not use reasonable care in engaging in those activities, they generate a nonreciprocal risk and therefore take responsibility if the risk is realized in an injury. This is negligence based liability. In case of hazardous activities, the reciprocity of risks does not apply and people who engage in such actions will be held liable for the results. This is strict liability.[754]

In this regime, there is a general principle of responsibility which holds that in order to do justice, liability must depend on the responsibility of the injurer. Responsibility is analysed in terms of causality, not in terms of fault. The

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[750] Thomas Douglas, *Medical Injury Compensation: Beyond 'No-Fault'*,Med Law Rev (2009) 17 (1)30 http://medlaw.oxfordjournals.org/content/17/1/30.full?sid=d8d5811b-6789-424e-ad1d-28fa200d1427 . Last visited on 7-10-2016 at 15.54
[751] Jules et al.,supra note 724
[752] *Id*
[753] Tudor supra note 726
[754] *Id*,

principle of autonomy and negative liberty states that each individual is free to exercise his autonomy until his doing so invades the space of others. At the point of invasion, he is either harming another or invading another's right. Since it does not matter whether the invasion is innocent or deliberate, liability imposed upon invaders is strict.[755]

5.4 COMPENSATION AND MEDICAL NEGLIGENCE

Compensation is derived from a Latin word '*compensare*' meaning 'wiegh together'.[756]In Roman law it is phrased as 'Suum cuique tribuere' means 'give to each man that which is his right'[757].The concept of compensation is derived essentially from the affirmation that the scales of justice should be on an even balance. If someone infringes legal right, he must pay the fair equivalent says, the Scottish law**.**

Damages is described as a sum of money given as compensation for loss or harm of any kind.[758] Lord BLACKBURN in *Livingstone v. Rawyards Coal Co*[759].expressed,

> I do not think, there is any difference in opinion as to being a general rule that, where any injury is to be compensated by damages, in settling the sum of money to be given for reparation of damages, you should as nearly as possible get at that sum of money which will put the person who has been injured,or who has suffered, in the same position as he would have been if he had not sustained the wrong for which he is now getting compensation or reparation.[760]

There is no difference in principle applied to the assessment of damages in a medical negligence case from other actions for personal injuries.[761] The compensatory function of law has been given a very wide connotation by

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[755] Coleman, Jules L. *Tort Law and the Demands of Corrective Justice*, Indiana Law Journal: Vol. 67: Iss. 2, Article 6.(1992)
[756] JOHN MUNKMAN,DAMGES FOR PERSONAL INJURIES AND DEATH 1-7 (3rd.ed. 1966)
[757] *Id*
[758] *Id*
[759] (1980)5 App.Cas. 25
[760] JOHN MUNKMAN supra note 756
[761] JAGDISH SINGH & VISHWA BHUSHAN, MEDICAL NEGLIGENCE AND COMPENSATION164-170(2nd ed.199).

Supreme Court in India[762] by taking in its fold mental agony, harassment, actual loss and expected loss, humiliation, insult, emotional suffering etc.

In case of death due to medical negligence, the valuable life is abruptly terminated. The purpose of awarding compensation is to indemnify the loss of to the dependants or to the estate. The determination of amount of compensation is basically a net balance of the loss and gain to the survivors or dependants. It was held by the Court of Appeal in UK that, the purpose of an award in Tort is to make good the loss suffered as a result of the wrong done[763].

5.4.1 DAMAGES

Normal remedy for under civil law –whether it is personal injury or damage to property, or financial loss-is a right to recover damages.In the Victorian cases, it is observed by jurists that there was a warning against excessive compensation and it was insisted that damages are not rewards but simply compensation.[764] But the impossibility of ascertaining the amount of money which can ' actually' compensate personal injury, was prime concern of the judges.

The major issues in deciding the damages are two. One, the items of loss or injury in respect of which damages are given and second, methods to quantify these items in monetary terms. In general, damages are given for all kinds of injury caused by an unlawful act, and for its consequential loss and expense. In personal injuries, these factors include loss of earnings, pain, loss of employment etc. Quantification is easy when the loss has financial character. For example, loss of wages or profit, medical expenses etc. In this case, it is simply a matter of arithmetic calculation. But some other losses such as loss of a limb, hearing capacity etc. involve a broad estimate. In such cases, courts do take guidance from compensation awarded in similar and comparable cases[765]. In the words of COCKBURN, C.J:[766]

> In assessing [the] compensation the jury should take into consideration two things; first, the pecuniary loss [the plaintiff] sustains by the

[762] Ghaziabad Development Authority s. Balbir Singh (2004) 5SCC 65
[763] Wells v.Wells[1999] AC 345
[764] British Transport Commission v. Gurley [1956] A.C. 185
[765] SINGH & BHUSHAN supra note 761
[766] Fair v. London and North Western Rail.Co. (1969)21 L.T.326

> accident; secondly, the injury he sustains in person, or his physical capacity of enjoying life. When they come to the consideration of the pecuniary loss they have to take into account not only his present loss, but his incapacity to earn a future improved income[767]

Things acquire value by and in terms of society's judgement. When courts assess damages for personal injuries, they endeavour to reach at a fair social valuation. They don't consider the probably enormous value that a person would place on his own life. But they will dispassionately take a neutral value which the society at large on the basis of the prevailing money values in that society would give to it[768].

DENNING, M.R. said, "….the award of damages in personal injury cases is basically a conventional figure derived from experience and from awards in comparable cases."[769]

Most actions against medical practitioners are claims in respect of personal injury or death and the consequential financial loss, and there is no difference in the principles applied to the assessment of damages in medical negligence cases from other actions for personal injuries.

"A claim in negligence will only lie where damage has been caused that is worth suing for."[770] Proof of damage is essential in a claim in negligence.

5.4.2 TYPES OF DAMAGES

The fundamental principle of an award of damages is that the injured party should be fully compensated. He is entitled to be restored to the position that he would have been in, had the tort not been committed. The classic statement of Lord BLACKBURN in *Livingstone v. Rawyards Coal Co*.[771] explains proposition,

> where any injury is to be compensated by damages, in settling the sum of money to be given for reparation or damages, you should, as nearly as possible, get that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been in if he had not sustained the wrong for which he is now getting his compensation or reparation.

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[767] JOHN MUNKMAN,DAMGES FOR PERSONAL INJURIES AND DEATH 10-11(3rd.ed. 1966)
[768] SINGH & BHUSHAN supra note 761
[769] Ward v. James [1965]I All.E.R. 563, JOHN MUNKMAN supra note 767 at 16-17
[770] Rothwell v. Chemical & Insulating Co.Ltd [2006] EWHC Civ 27
[771] (1980)5 App.Cas. 25

The statement was reaffirmed by Lord LIOYD in *Wells v. Wells.*[772] "The task of the court in assessing damages for personal injury is to arrive at a lump sum which represents, as nearly as possible, full compensation for the injury which the plaintiff has suffered."

Claimant is entitled to be restored to the position, he would have been in, if the injury would not have caused by the defendant. But practically this is almost impossible in many cases. No amount of money can restore a man to his original position who lost his leg due to medical negligence. No amount of money can reduce the grief of a mother who lost her child to the negligence of a surgeon. In such cases compensating becomes an intricate function .The principle applied by the courts is that non-pecuniary damages should be 'fair' and 'reasonable' leaving the big question of what is fair and reasonable to be answered by the judges in each case.

Aggravated damages

When the award is not limited to the pecuniary loss that can be specifically calculated, the court may take into account, the manner in which the tort was committed in assessing the damages. If they were injuring the proper feelings of dignity and pride, then aggravated damages can be given. Aggravated damages are compensatory. But they are higher than would normally be the case to reflect the greater injury to the plaintiff. In *Kralji v.McGrath*[773], it was held that aggravated damages should not be awarded in an action for negligence against doctors, notwithstanding that the medical evidence indicated that the injured party's treatment had been "horrific". If on the other hand, the particular treatment increased plaintiff's pain and suffering, this should be reflected in a higher award under this head.[774]In *Broome v. Cassel & Co.Ltd*,[775]Lord REID said that the commission of a tort in a malicious,insulting or oppressive manner may aggravate the claimant's injury. It is arguable that some form of treatment could be regarded as oppressive or insulting: sterilisation of a competent adult

[772] [1999] 1 A.C. 345
[773] [1986] 1 All E.R.54
[774] MICHAEL A JONES, MEDICAL NEGLIGENCE 970-1000 (4th ed. 2008)
[775] HL 23 FEB 1972

without consent for example.[776] In *Richardson v.Howie,*[777] the Court of Appeal clarified that the aggravating factors should be compensated through the award of general damages.

Exemplary damages

Exemplary damages are punitive in nature and are awarded in addition to the compensatory damages in order to teach the defendant that "tort does not pay". Exemplary damages aims to punish the wrongdoer. English common law has limited award of such damages to only two circumstances. One is oppressive, arbitrary or unconstitutional actions by servants of the government and the other is a conduct which has been calculated to make a profit for himself that may well exceed the compensation payable.[778]But the trend is gradually changing in UK. There are deliberations at the government level on whether that can be allowed in negligence cases as well with a rational basis[779].If approved, it will open the way for exemplary damages for clinical negligence as well in respect of conscious wrong doing which is outrageous[780].

5.5 REMOTENESS OF DAMAGE

Damages, in general, are awarded for the consequential loss and other expenses incurred as a result of injury. In some cases, it can be argued that the loss is too remote to the injury to suffer. Remoteness of damage is a confusing subject, not because it is difficult in itself, but because, like an archaeological site, it has been overlaid with successive theories which are inconsistent with one another[781].

In Tort, the defendant is not liable unless the plaintiff had a duty towards the plaintiff to 'take care'. He does not have any duty if the plaintiff is out of the

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[776] JONES supra note 774
[777] [2004]EWCA Civ 1127
[778] JONES supra note 774
[778] [2004]EWCA Civ 1127
[779] Civil Law Reforms Draft Bill (2009). http://www.justice.gov.uk/docs/cp0907.pdf Last visited on 09-08-2016 at 22. 35
[780] JONES supra note 774
[780] [2004]EWCA Civ 1127
[781] MUNKMAN supra note 154

range of defendant's activities and no reasonable man would expect the plaintiff to sustain any harm.[782]

It was a long debated issue, whether compensation can be given for nervous shock. If nervous shock accompanied with physical injury, it will be a part of pain and suffering. Though it is possible at a later stage to have adverse physical effects, if it is not immediately accompanied with physical injury, it was not accepted as a cause of action. The justification in these cases was that the damage is 'too remote'. It was considered as harm 'too fanciful and speculative 'to be recognized by the law'[783].

5.5.1 REASONABLE FORESEEABILITY

The defendant who is guilty of negligence is only liable to compensate for those consequences of his action which were reasonably foreseeable.[784] It is not required that the precise nature of the injury should be foreseeable. It is enough if the type, kind degree or order of harm could have been seen in a general way[785].Where the plaintiff suffers no damage to his person or property but sustained economic loss, the law does not usually permit him to recover that loss, because it is too remote to be a head of damage[786].Mere economic loss unaccompanied by damage to person or property is irrecoverable in an action for negligence. The test of foreseeability determines the liability in damages for the result of wrongful act[787]

5.6 ELIGIBILITY UNDER GENERAL LAW

Any adult person of sound mind is entitled to ask for compensation, for the injuries he suffered due to medical negligence[788]. In case of a minor or an unsound mind person the claim can be made through next friend. That means

[782] MUNKMAN supra note 154
[783] *Id*
[784] Overseas Tankship(UK) Ltd v. Morts Dock and Engineering Co.Ltd [1961] AC 388
[785] Bradford v. Robinsons Rentals Limited [1967]1 All ER 267
[786] SCM9UK0 Ltd. v.. W.J. Whitfall & Sons Ltd. [1971] 1 QB 337
[787] BAG supra note 345
[788] BAG supra note 345

those who are not capable of protecting their interest due to immaturity or unsoundness of mind can also approach the court through their next friend[789].

5.6.1 LEGAL REPRESENTATIVE

Under the Legal Representatives' Suits Act, 1855, personal injury claims cannot be commencing by the executor, administrator or representative of the deceased. The Act is intended to protect wrong done to property of the deceased. However such person will also have *locus standi*, if he claims on behalf of wife, husband, parent and child[790].Legal representative means a person who in law represents the estate of the deceased and includes any person who intermeddles with the estate of the diseased, and where a party sues or is sued in a representative character, the person on whom the estate devolves on the death of the party so suing or sued.[791]The Madras High Court [792]has held that the word representative used in the Fatal Accidents Act, 1855 means and includes all or any of the persons for whose benefit a suit under the Act can be maintained, and that the persons are representatives in the sense that they are the persons taking the place of the deceased in obtaining reparation for the wrong done. This view was followed by various courts consistently. [793] Therefore under this Act compensation is available to those members of the family of the deceased, who suffer monetary loss as a result of death of the said person caused by wrongful act. Just compensation is that which would enable the legal representative to receive or earn such pecuniary benefit as they could have obtained from the decease, if he had lived his normal life.[794]

A modified version of the maxim *auctio personalis moritur cum persona* can be seen in Indian Succession Act.[795]It provides that all rights to prosecute or defend any action for or against a person at the time of death, survive to against his executor or administrator.

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[789] Order 32 of Civil Procedure Code.1908
[790] Section 1A of Fatal accidents Act,1855
[791] Section 2(11)of the Code of Civil Procedure,1908
[792] Johnson v. The Madras Railway Company ILR (1905)Mad 479
[793] Palani Ammal v. Safe Service Ltd. 1966 ACJ 19(Mad),State of Rajasthan v. Parvati Devi AIR1966 Raj 210,Himachal Government Transport v. Joginder Singh 1970 ACJ 57 (Punj)
[794] Surinder Kaur v. Bhagat Singh (1978)80 Punj LR 732,as quoted by K.SAXENA & M.S.ANSARI,PRINCIPLE ON QUANTUM OF COMPENSATION 34-35(1988)
[795] Section 306

5.6.2 MODE OF ASSESSMENT

Common Law

Under the general principles of tortious liability, the medical practitioner who caused injury or damage by negligence is bound to pay compensation. The medical man is bound to compensate the family of the deceased patient whose death is caused by his wrongful act, neglect or default. [796] In Sideway's case[797],the House of Lords did not object to action brought against the executors of the estate of the deceased neuro –surgeon, though the allegation of negligence was not established in the case. However, if the complainant hired the services of the hospital and there is no privity of contract between complainant and the doctor, only the hospital will be liable to pay compensation[798].

Lord WRIGHT has laid down the general rule of assessing damages in the following ways.

> The damages are to be based on the reasonable expectation of pecuniary benefit or benefit reducible to money value. In assessing damages which may be legitimately pleaded in diminution of losses must be considered. The actual pecuniary loss of each individual entitled to sue can only be ascertained by balancing, on the other hand, the loss to him of the future pecuniary benefit, and, on the other, any pecuniary advantage which from whatever source comes to him by reason of death.[799]

Lord BLACKBURN[800]said,

> I do not think, there is any difference in opinion as to its being a general rule that, where any injury is to be compensated by damages, in settling the sum of money to be given for reparation of damages, you should as possible get at that sum of money which will put the person who has been injured, or who has suffrered,in the same position as he would have been in if he had not sustained the wrong for which he is now getting his compensation or reparation.[801]

VISCOUNT SIMON formulated a test in the following way. First, the deceased man's expectation of life has to be estimated having regard to his age, bodily health and the possibility of premature determination of his life by later accidents. Thereafter, the amount required for the future provision of his wife

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[796] Section 1A of Fatal Accidents Act,1855
[797] Sideway v. Bethlem Royal Hospital Governors [1985]1 All ER643
[798] BAG supra note 345
[799] BAG supra note 345
[800] Livingstone v. Rawyards Coal Co.,(1980) 5 App.Cas.25
[801] MUNKMAN supra note 154

shall be estimated having regards to the amounts he used to spend on her during his lifetime and other circumstances. Then the estimated annual sum is multiplied by number of years of the man's estimated span of life, and the said amount must be discounted so as to arrive at the equivalent in the form of a lump sum payable on his death. And further deductions must be made for the benefit of accruing to the widow from the acceleration of her interest in his estate. Fifthly further amounts have to be deducted for the possibility of wife dying earlier if the husband had lived the full span of life, and it should also be taken into account that there is the possibility of widow remarrying much to the improvement of her financial position[802].

Lord WRIGHT[803]stated that

> The starting point is the amount which was the earning of the deceased. But it has to be ascertained on the basis of the regularity of his employment. Then the amount which would have required for his personal expenses is to be calculated. The balance will be a general figure which will be turned in to a lump sum by taking a certain number of years' purchase. That sum however had to be taxed down by having due regards to the uncertainties such as remarriage etc.

Lord DIPLOCK formed another principle. To assess damage, it is necessary to form a view on three matters. Calculate the value of the material benefit for his dependants which deceased would have provided out of his earnings for each year in future during which he would have provided them if he had not been killed. Then the value of any material benefits which the dependants would have obtained in each such year from sources(other than insurance) which would not have been available to them ,had the deceased been alive.Thirdly the amount of capital sum with which prudent management will produce annual amounts equal to the difference between first and the second value for each of the years during which the deceased would have provided material benefits for the dependants had he not been killed[804].

The Court of Appeal in England held that where the plaintiff received unemployment benefit to which defendant was a contributing party, such sums

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[802] Nance v. British Columbia Electric Rly .Co.Ltd.[1951]AC 601
[803] Davies v. Powell Duffryn Associated Collieries Ltd.[1942]AC 601
[804] BAG supra note 345

must be deducted from the award. These judgments underscored a philosophy that personal injury benefits are only compensatory.[805]

Much earlier in 1879, FIELD, J.[806] warned the jury in this way,

> You cannot put the plaintiff back again into his original position, but you must bring your reasonable common sense, to bear, and you must always recollect that this is the only occasion on which compensation can be given.[The plaintiff] can never sue again for it. You have, therefore, now to give him compensation, once and for all. He has done no wrong; he has suffered a wrong at the hands of the defendant, and you must take care to give him full fair compensation for that which he has suffered.[807]

The general rule is that the injured party should give credit for all sums he received in diminution of his loss, save for exceptional cases such as insurance benefits. In *Hudson v. Trapp*[808], Lord BRIDGE said that, "The classic heads of exception to the basic rule are: Moneys accruing to the injured plaintiff under policies of insurance for which he had paid premiums". Disablement pension does not operate to reduce damages.[809]It is a kind of pension which the plaintiff is entitled for, because of the premiums which he has paid,the wrong doer should not be allowed to appropriate the benefit[810].Similarly the amount which is given to the plaintiff by third parties out of sympathy can also not be deducted[811].

Indian Law

In India**,** compensation payable to a victim of an accident is assessed separately as pecuniary damages and special damages. Pecuniary damages are those which the victim has actually incurred and which is capable of being calculated in terms of money; whereas non-pecuniary damages are those which are incapable of being assessed by arithmetical calculations. In order to appreciate two concepts pecuniary damages may include expenses incurred by the claimant: (i) medical attendance; (ii) loss of earning of profit up to the date of trial; (iii) other

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[805] *Id*
[806] Phillips v. South Western Rail.Co. (1879)
[807] MUNKMAN supra note 154
[808] [1988]3 WLR 1281
[809] Pyane v. Rly. Executive[1952]1KB 26
[810] Jude v. Hammersmith West London and St. Mark's Hospital [1960] 1 WLR328
[811] Redpath v. Belfast and County Down Rly[1947]NI167

material loss. So far non-pecuniary damages are concerned, they may include (i) damages for mental and physical shock, pain suffering, already suffered or likely to be suffered in future; (ii) damages to compensate for the loss of amenities of life which may include a variety of matters i.e. on account of injury the claimant may not be able to walk run or sit; (iii) damages for the loss of expectation of life, i.e. on account of injury the normal longevity of the person concerned is shortened; (iv) inconvenience, hardship, discomfort, disappointment frustration and mental stress in life." observed the Supreme Court[812]Judiciary has put in a lot effort and thought in identifying an appropriate test in quantification of damages.[813]Supreme Court in *Gobald Motor Service Ltd. v. R. M. K. Velu-swami* observed:[814]

> It would be seen from the said mode of estimation that many imponderables enter into the calculation. Therefore, the actual extent of the pecuniary loss to the respondents may depend upon data which cannot be ascertained accurately, but must necessarily be an estimate, or even partly conjecture. Shortly stated, the general principle is that the pecuniary loss can be ascertained only by balancing on the one hand the loss to the claimants of the future pecuniary benefit and on the other any pecuniary advantage which from whatever source comes to them by reason of the death, that is, the balance of loss and gain to a dependent by the death must be ascertained.

In Municipal Corporation of Delhi v. Subhagwanti[815],the Supreme Court relied upon another observation of Lord Wright in Davies's case[816] , according to which ' for the purpose of assessing the amount of compensation due to the beneficiaries, the amount of wages which the deceased was earning has to be ascertained after making allowance for the estimated amount which the deceased was spending on himself during his lifetime and then the balance should be turned into a lump sum by taking a certain number of years purchase". The income of the deceased had been capitalised for a period of 15 years on the basis of this formula by the High Court. This was approved toy the Supreme Court. In *Taff Vale Rly. Co. v. Jenkins,* [817]it was held that while estimating the

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[812] R.D. Hattangadi v. Pest Control (India) Private Limited (1995) 1 SCC 551,
[813] Muncipal Corporation of Delhi v. Subhagwanti AIR 1966 SC 1750
[814] AIR 1962 SC 1
[815] AIR 1966 SC 1750
[816] Davies v. Powell Duffryn Associated Collieries Ltd., 1942 AC 601,
[817] (1913 AC 1)

damages solatium cannot be awarded inasmuch as no damages can be awarded for injured feelings or on the ground of sentiment, but prospective loss to the dependants of the deceased can certainly be taken into consideration.

> The basis is not what has been called solatium, that is to say, damages given for injured feelings or on the ground of sentiment, but damages based on compensation for a pecuniary loss, but then loss may be prospective, and it is quite clear that prospective loss may be taken into account. It has been said that this is qualified by the proposition that the child must be shown to have been earning something before any damages can be assessed. I know of no foundation in principle for that proposition either in the statute or in any doctrine of law which is applicable; nor do I think it is really established by the authorities when you examine them.....

In *Nance v. British Columbia Electric Railway Company Ltd*.[818], it was held that the claim to damages in cases of death fell under two separate heads; first, what sums the deceased would have probably applied out of his income to the maintenance of his wife and family if the deceased had not been killed and would have lived the full span of life; second, what would have been the additional savings which the deceased would or might have accumulated during the period he would have lived but for the premature death, which would probably have accrued to his wife and family. For the purpose of arriving at the correct assessment under these two heads, Viscount Simon laid down the following principles[819] :

> Under the first head--indeed, for the purposes of both heads it is necessary first to estimate what was the deceased man's expectation of life if he had not been killed when he was (let this be 'x' years) and next what sums during these x years he would probably have applied to the support of his wife. In fixing x, regard must be had not only to his age and bodily health, but to the possibility of a premature determination of his life by a later accident. In estimating future provision for his wife, the amounts he usually applied in this way before his death are obviously relevant, and often the best evidence available through not conclusive, since if he had survived, his means might have expended or shrunk; and his liberality might have grown or wilted

[818] 1951 A.C. 601
[819] Quoted in Lachhman Singh v. Gurmit Kaur AIR 1979 P&H 50 FB

Interest theory

This theory has been laid down by the Supreme Court in *Surjit Singh v. The Co-operative General Insurance Society Ltd.*[820]In this case, it was held that as the claimants are getting a capitalised sum, the mode to work out what sum they should get is to see how much interest that amount fetches and if that interest equalizes the benefit they were getting from the deceased, then that amount should be awarded as compensation[821].

Though this theory was reiterated in Naresh Kanta's Case,[822]it was discarded by the full bench of the same High Court in Lachhman Singh's Case[823].

"… this interest theory cannot be adopted as an inflexible principle for the purpose of assessing the compensation specially in these days when the purchasing power in terms of money is being eroded after short intervals on account of run- away inflation." The Court categorically observed that,

> In present day India, when our economy is not so highly developed as in western countries and the banking system has not taken deep roots especially in the villages, it is too unrealistic to adopt interest theory for determining the damages. In a large number of villages, there are neither any bank nor are the people accustomed to make investments therein. Besides, bank interest rates are not stable and static and the same go on fluctuating in view of the inflationary trends in the economy. Only a decade back, the normal bank interest rate did not exceed 4 per cent. As inflation in course of time becomes an essential part of the economy, the banks, in order to mop up the surplus money in the hands of the people, contrived of the inducement to pay higher rates of interest and these interests have been going up from time to time. The adoption of interest theory presumes that the claimant will invest the amount of claim in the bank which will ensure the amount of monthly dependency. In this manner, the claimant while getting the monthly interest will also be having the capital invested in the bank as intact. This argument may be further advanced for the purpose of further reduction in the total amount of compensation. To my mind, the interest theory is impracticable and unrealistic and will not be a proper yardstick for determining the correct amount of compensation.

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[820] (1974) 76 Pun LR 353 (1).
[821] Quoted in Joki Ram v. Smt. Naresh Kanta (1977)79 Punj LR328
[822] Joki Ram v. Naresh Kanta (1977)79 Punj LR328
[823] Lachhman Singh v. Gurmit Kaur AIR 1979 P&H 50 FB

Multiplier method

The multiplier method of assessing damages is calculating the net pecuniary loss upon an annual basis and to arrive at the total award by multiplying the figure assessed as the amount of the annual dependency by a number of years purchase. That means the number of years the benefit was expected to last taking into consideration the imponderable factors in fixing either the multiplier or the multiplicand[824].When person is on the threshold of his career, his income is less, but he has a longer period to serve and as such a higher "multiplier" is called for. A lower "multiplier" is justified as the person grows old, and his income and contribution to the family increases.[825] Multiplier is a notional figure which represents a number of years by which the multiplicand must be multiplied in order to calculate the future losses. The figure is arbitrary and ranges from 10-20 depending upon the approach of the court in each case.[826]

In *Subhagwanti's* case,[827] the deceased was 30 year old. The multiplier of 15 years was used by the Supreme Court in calculating the amount of compensation. In another case[828], the lady who was just about 23 years had 35 years of service remaining. Keeping in mind all the relevant facts and contingencies, a suitable multiplier of 20 was taken by the Supreme court. In *Krishnakumari Gupta's* case[829], the High Court adopted the multiplier of 16 years. A multiplier of 20 was used in where the complainant lost vision of one eye and was at the age of forty.[830].In *Damyanti Devi v. Sita Devi*,[831] the Court held that it was not necessary to make any deduction on account of the lump sum payment and the amount of annual loss was multiplied by the number of years by which the life had been cut short. *Parsani Devi v State of Haryana*,[832] the amount of damages was arrived as by multiplying the annual dependency

[824] Madhya Pradesh State Road Transport Corporation v. Sudhakar AIR 1977 SC1189
[825] Krishna Kumari Gupta v.Gurbux Sheesh Singh 1985 ACJ 457
[826] SINGH & BHUSHAN supra note 761
[827] Muncipal Corporation of Delhi v. Subhagwanti AIR 1966 SC 1750
[828] Madhya Pradesh State Road Transport Corporation v. Sudhakar AIR 1977 SC1189
[829] Krishna Kumari Gupta v.Gurbux Sheesh Singh 1985 ACJ 457
[830] Ram Babu v. Anjani Kishore Prasad 1998(2) CPR224
[831] 1972 AC 334
[832] (1973) 75 P.L.R. 812

by the number of years till the age of retirement. The Court observed in *Lachhman Singh v. Gurmit Kaur* [833] that

> …the most 'just and reasonable' view appears to be that the total amount of damages should be arrived at by multiplying the annual dependency by a suitable multiplier. The sole basis of awarding compensation to the dependents of the deceased is that on account of culpable negligence or default of the offender, a valuable life who was the source of livelihood to the claimants is cut short. Before the termination of life, the deceased was making some earning either through salary in Government service or any business, enterprise or in any other manner, or was getting earning through his own business or cultivation of land. A part of the same he was spending for his own maintenance and some part, if not the whole, was being utilised for up-keep and maintenance of the dependants who may be his widow, parents or his children. There can be cases where after spending the earnings on all the members of the family, still surplus may be left and may have been utilised for bringing into existence an estate or property. Thus, abrupt termination of life results in loss to the dependants or to the estate. The basic figure of annual dependency has, thus, to be determined after excluding the amount which the deceased was spending on himself or which he was investing in some capital investment or formation of the estate.

Fatal Accidents Act

Personal injuries are generally compensated under Law of Torts. A specific legislation for providing damages to the dependants of the deceased was enacted for the first time in India in 1855, through Fatal Accidents Act; 1855.This Act entitles the dependants for compensation through pecuniary damages.

The plaintiff, in order to succeed an action under this act, has to prove that, by the death of the deceases, he has lost a reasonable probability of pecuniary advantage. Compulsory damages for wrongful death must be limited to the pecuniary loss to the beneficiaries[834].The general principle is that, the pecuniary loss can be ascertained only by balancing on the one hand, the loss to the claimants of the future pecuniary benefit and on the other, any pecuniary advantage which from whatever source comes to them by reason of death. That means the balance of loss and gain to the dependant by the death must be ascertained.

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[833] AIR 1979 P&H 50 FB

[834] Section 1A of Fatal Accidents Act, 1855.

Since the elements which determine the value of the deceased to the beneficiaries are necessarily personal in nature, there can be no exact or uniform rule for measuring the value of human life.[835]The Act gives a detailed list of people who can recover damages for the loss. That is, compensation for pecuniary loss sustained by the dependants.[836] Damages recoverable for the benefit of the estate is also available in its details.[837]It also provides for recovery for mental agony, suffering and loss of expectation of life. In awarding damages, there shall not be duplication of the same claim. If the person taking benefit under both the heads is the same, he cannot be permitted to recover twice over for the same loss. If any part of the compensation representing the loss of the estate goes into the calculation of personal loss that portion shall be excluded in giving compensation and vice versa.

Heads of damage

A pecuniary award is a composite figure made up of several parts. Some part is calculated in economic terms such as loss of income or future earnings. But it contains non-economic damages also. They are not calculated in money terms but proceeds on a conventional basis. Non-economic damages are compensation for pain, suffering and loss of amenities. Damages are to compensate both pecuniary and non-pecuniary losses. Economic damages are called 'special damages' which constitute loss of earnings expenses incurred in treatment as a result of accident and future pecuniary loss. Non-economic damages or 'general damages' are for compensating other kinds of losses, such as, pain and suffering, loss of enjoyment of life. And shortened expectation of life.

Special Damages

The pecuniary loss to the aggrieved party is assessed based upon a data which cannot be ascertained accurately.[838]These can be more easily computed and are generally larger than general damages. They include the cost of best available medical treatment, loss of earnings, nursing care, cost of special equiments,cost

[835] C.K.Subramania Iyer v. T.Kunjikuttan Nair AIR1970 SC 376
[836] Section 1supra note 834
[837] Section 2 supra note 834
[838] Sheikhpura Transport Co. Ltd.v. Northern India Transporters Insurance Company ltd. AIR1971 SC1624

of taxi fares to attend treatment etc.[839]The principle of working out a suitable multiplier is the only just and equitable method because the same takes into considerations not only the age of the victim, but also the ages of the dependants and all uncertainties of life., both in the realm of enhancement in the income as well as factors justifying reduction in the amount of compensation.[840]

- Loss of Earnings

Loss of earning has to be assessed between the date of accident and the date of trial. An injured party is entitled to recover damages in respect of any resultant loss of wages, salaries and fees. The plaintiff's real claim of special damages is the amount of his net loss. The particulars are necessary in order to enable its calculation. Other deductions are income tax which the plaintiff would have paid, any compulsory deductions that he would have made for example, and the contributions that he would have made to the National Insurance and similar obligatory payments and superannuation or pension contributions.[841]

- Loss of Future earnings

There is difference between an award for loss of earnings and for loss of earning capacity. Compensation for loss of future earnings is awarded for real assessable loss proved by evidence. On the other hand compensation for loss/reduction in earning capacity is awarded as part of general damages for pain and sufferings as well as for loss of amenities. After the judgment in *Jefford v. Gee*[842] the future earning capacity is quantified separately in England.[843]The amount under this head is basically the net balance of the loss and gain to the survivors or the dependants. It is not possible to visualise all the uncertainties or assess in exact terms. Therefore there bound to be a general estimate[844].

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[839] SINGH & BHUSHAN supra note 761
[840] Lachhman Singh v. Gurmit Kaur AIR 1979 P&H 50 FB
[841] Colledge v. Bass Mitchells & Butlers Ltd.[1988]1 All ER 536
[842] [1970]2 QB130
[843] BAG supra note 345
[844] *Id*

- Expenses for Medical Treatment

The plaintiff is entitled to recover the medical expenses which he incurred The cost of medical expense includes the cost of nursing, fees of the consultants, cost of medicine and other ancillary charges[845].The injured plaintiff is not obliged to avail himself of free hospital treatment. The claimant can elect to be treated as a private patient but the court may be reluctant to award damages on what would be a speculative basis[846].

General Damages

The principles governing assessment of damages are that the damages must be fair and reasonable. A just proportion must be observed between damages which are less serious and those are more serious injuries. An attempt must be done to award a sum according to the general assessment standards made over the years in comparable cases. In the words of Lord SALMON[847], "the damages awarded should be such that ordinary sensible man would not instinctively regard them as either mean or extravagant, but would consider them to be sensible and fair in all circumstances".

- Pain and suffering

Pain and suffering is recognized by the law as a head for which damages may be given. Pain and suffering can be physical or mental. They are subjective and difficult to measure in monetary terms. Therefore exact estimation of damages is not possible. Its calculation is a matter of degree which varies from case to case. The assessment of pain and suffering damages in cases of personal injury remains a daunting task for the courts in most legal jurisdictions[848] . An award can be made to cover physical pain and suffering, psychiatric symptoms and nervous shock.[849]Prospective as well as past suffering is allowed in common

[845] BAG supra note 345
[846] Lim Poh Choo v.Camden and Islington Area Health Authority[1980]AC 174
[847] Fletcher v. Autocar and Transporters Ltd.[1968]2QB 322
[848] Vaia Karapanou, *Pain and suffering damages based on QALYs: Combining insights from health economics and cognitive psychology*, Rotterdam Institute of Law and Economics (RILE) Working Paper Series No. 2011/1(April 1, 2011). https://www.esl.eur.nl/fileadmin/ASSETS/frg/arw/RILE/RILE_Working_paper_Pain_and_suffering_damages_based_on_QALYs.pdf. Last visited on 10-08-2016 at 17.50
[849] SINGH & BHUSHAN supra note 761

law.[850]The medical care and treatment are included in the actual and prospective suffering. It was opined by the court that state of unconsciousness of the patient eliminates pain and suffering which experienced by being felt or thought, irrespective of the serious nature of the injury.[851] In all cases some extra allowance must be made for unpleasant surgical operation. Pain and suffering includes mental distress. Where the plaintiff realises the extent and severity of injuries by which his activities are being reduced permanently to a lower level, he must be compensated for the mental anguish suffered from such injuries.[852] A plaintiff can claim damages even for fright, nervousness, grief, anxiety, worry, mortification, shock, humiliation, indignity, embarrassment, apprehension, terror, or ordeal.[853] All of these intangible injuries, it can be seen, are varieties of feeling as opposed to objective outcomes.[854]The pain and suffering for which recovery may be had includes that incidental to the injury itself and also such as may be attributable to subsequent surgical or medical treatment.[855] It is not essential that plaintiff specifically allege that he endured pain and suffering as a result of the injuries specified in the pleading, if his injuries stated are of such nature that pain and suffering would normally be a consequence of them.[856] The concept of pain and suffering also commonly includes the mental distress accompanying or resulting from injury.[857] Admittedly it is difficult to distinguish mental distress from physical pain in every case but certain types of disturbance which are perhaps more emotional

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[850] Heeps v. Perrite,Ltd [1937]2 All E.R.60
[851] Wise v. Kaye [1962]1QB 638
[852] Birkett v. Hayes [1982]1WLR 816
[853] *Pain and Suffering*,US legal.com. Http://damages.uslegal.com/compensatory-damages-in-personal-injury-cases/pain-and-suffering/. Last visited on 10-08-2016 at 16.44
[854] Peter A. Ubel and George Loewenstein, *Pain and Suffering Awards: They Shouldn't Be (Just) about Pain and Suffering.* Journal of Legal Studies,195-216 (vol. 37 June 2008). http://www.cmu.edu/dietrich/sds/docs/loewenstein/painSufferingAwards.pdf. Last visited on 10-08-2016 at 17.19
[855] Marcus L. Plant, *Damages For Pain And Suffering*, Ohio State Law Journal 200-211 (Volume 19, Issue 2 1958). https://kb.osu.edu/dspace/bitstream/handle/1811/68054/OSLJ_V19N2_0200.pdf. Last visited on 10-08-2016 at 16.49 quoting SEDGWICK, A TREATISE ON MEASURE OF DAMAGES 920 (9th ed. 1912)
[856] Lane v. Southern Ry. Co., 192 N.C. 287, 134 S.E. 855 (1926). *Id*
[857] Marcus L. Plant, *Damages For Pain And Suffering*, Ohio State Law Journal:200-211 Volume 19, Issue 2 (1958). https://kb.osu.edu/dspace/bitstream/handle/1811/68054/OSLJ_V19N2_0200.pdf. Last visited on 10-08-2016 at 17.03

than physical are commonly allowed to be taken into account in the recovery of pain and suffering. Among these are such things as humiliation or embarrassment connected with scars or disfigurement incurred as a result of the injuries. Shock and nervous disturbances comes under this heading. Damages are awarded for the shock suffered as a result of the accident. A shock is described as a state of mind, anywhere between nervous shock resulting in psychiatric illness on the one hand and sorrow and grief from loss of pleasure on the other hand[858]. The main difficulty about pain-and-suffering damages seems to be, that they are unpredictable and involves a lengthy procedure in proving its presence[859].

- Loss of enjoyment of Life

This can be from physical or mental consequences of the negligent act.[860]The assessment is subject to the mental suffering. It is settled by House of Lords that it is in respect of objective loss of amenities that damages are calculated. An additional sum for mental suffering can be awarded if it is proved.*Heep v. Perrite Ltd*[861] was a case where the plaintiff lost both his hands.GREER,L.J. said that the following facts had to be taken into account."…the joy of life will have gone for him. He cannot ride a bicycle, cannot kick a football. At any rate, if he can kick a football he cannot catch one. He cannot have any of the usual forms of recreation which appeal to the ordinary healthy man…."[862]

The loss of amenities of life has to be assessed on proper consideration on the effect of injuries on the health and spirit of the injured in carrying out the normal social and personal life. The complainant is entitled to damages for the inability to enjoy life in various ways, e.g., inability to play games, sing, dance, enjoy sexual functions, etc. In every case, the personal circumstances of the plaintiff

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[858] Schneider v. Eisocitch[1960]2 QB 430
[859] Ronen Avraham, *Putting A Price on Pain-and-Suffering Damages: A Critique of the Current Approaches and a Preliminary Proposal for Change*, Northwestern University Law Review 87-120 (Vol. 100, 2006)
[860] Lane v. Southern Ry. Co., 192 N.C. 287, 134 S.E. 855 (1926). *Id*
[860] Schneider v. Eisocitch
[861] [1937]2 All E.R.60
[862] MUNKMAN supra note 154 at 102-103

must form the background of the assessment. Age is an important factor to consider while assessing damages under this heading.[863]

In an action for personal injuries, it is irrelevant to consider whether the victim is unable to enjoy personally the award of damages.[864]The following factors are considered while assessing such damages. The dependence of the injured on others in daily life, inability to look after others, care ,render services, sexual impotency, premature on-set of menopause, loss of prospect of marriage and inability to lead the life which the injured used to lead or which he might have led or wanted to lead.[865]

- Reduction in expectation of Life

From the loss of pleasures of life, it is a natural consequence to the loss of enjoyment of life. Right to life is guaranteed by the Constitution[866].The prospect of an enjoyable life is shortened or reduced by injuries sustained by the claimant. It is not merely the fact that he may feel personal misery in knowing that his life is shortened. It is more important and objective fact that he has been deprived of perhaps many happy years. This has been expressed by Lord ROCHE[867] in 1937.

> I regard impaired health and vitality, not merely as cause of pain and suffering, but as a good thing in itself. Loss of expectation of life is a form in which impaired health and vitality may express themselves as a result. In such loss, there is a loss of temporal good, capable of evaluation in money, though the evaluation is difficult...[868]

The claim for loss of expectation of life can be advanced even when the claimant had been killed. This claim is also available on behalf of a deceased person's estate. The reduction of happy and enjoyable life must be taken into consideration while assessing damages.[869] This is apart from the financial

[863] MUNKMAN supra note 154 at 102-103
[864] BAG supra note 345
[865] SINGH & BHUSHAN supra note 761
[866] Article 21 of Indian Constitution
[867] Rose v. Ford [1937]3 All.E.R.359
[868] MUNKMAN supra note 154 at 104-105
[869] BAG supra note 345

aspect. As Lord ROCHE[870] observed "…total loss of good life over part of the normal period of life has to be measured…"[871]

- Interest on award

There is a distinction between damages in respect of loss already incurred, for which interest may be awarded, and damages for future loss. Damages for future loss represent an accelerated receipt. Therefore interest in respect of future pecuniary loss is not awarded. General damages in respect of pain, suffering and loss of amenities attract interest. Whereas loss of future earning do not attract interest. The interest on award is calculated from the date of service of writ to the date of trial. Special damages should be dealt in broad terms while calculating interest.[872]

- Physical defects and disabilities

Defects and disabilities such as loss of limb, loss of eye sight, loss of ability to walk, presence of scar as a result of unnecessary operation. Disfigurement has always been regarded as an important element in assessing damages. In case of young people, the prospect of marriage is also impaired. Irrespective of whether there is loss of earning capacity or amenities, the total loss, or the impairment, of a limb or other part of the body or impairment of the body as a whole will attract substantial damages. However, the factor-such as loss of earning capacity- will make a difference to the quantum.[873] The term "disability", as so used, ordinarily means loss or impairment of earning power and has been held not to mean loss of a member of the body. If the physical efficiency because of the injury has substantially impaired or if he is unable to perform the same work with the same ease as before he was injured or is unable to do heavy work which he was able to do previous to his injury, he will be entitled to suitable compensation. Disability benefits are ordinarily graded on the basis of the character of the disability as partial or total, and as temporary or permanent. No

[870] Rose v. Ford [1937]3 All.E.R.359
[871] MUNKMAN supra note 154 at 104-105
[872] BAG supra note 345
[873] MUNKMAN supra note 154 at 94-95

definite rule can be established as to what constitutes partial incapacity in cases not covered by a schedule or fixed liabilities, since facts will differ in practically every case."[874]

5.6.3 AWARD OF COMPENSATION

In R.D. Hattangadi v. Pest Control (India) Private Limited,[875] the Supreme Court observed that the exercise for determination of compensation in accident cases involve some guess work, some hypothetical consideration and some amount of sympathy linked with the nature of disability. But these elements are required to be considered in an objective manner. In that case, the claimant was a retired judge and practicing when he met with an accident that caused 100% disability and paraplegia below the waist. While determining compensation payable to him the Court stated:

> When compensation is to be awarded for pain and suffering and loss of amenity of life, the special circumstances of the claimant have to be taken into account including his age, the unusual deprivation he has suffered, the effect thereof on his future life. The amount of compensation for non-pecuniary loss is not easy to determine but the award must reflect that different circumstances have been taken into consideration..[876]

In S*pring Medows hospitals case*,[877] the Court upheld the order awarding compensation in favour of the minor child taking into account the cost of equipment and the recurring expenses that would be necessary for the minor child who is merely having a vegetative life. The compensation awarded in favour of the parents of the minor child is for their acute mental agony and the lifelong care and attention which the parents would have to bestow on the child. Considering this judgment as an example to follow, in *Nizam's Institute's* case,[878] it was stated that,

> ...we are of the view that the facts and circumstances of the case justify the award to the Complainant of an amount of Rs.8 lakhs towards prospective charges for physiotherapy, nursing and associated expenses,

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[874] Ramachandrappa v. The Manager, Royal Sundaram Alliance Insurance Company Limited, (2011) 13 SCC 236
[875] (1995) 1 SCC 551
[876] See also,Ward v. James (1965) 1 All ER 563
[877] Spring Meadows Hospital & Anr v. Harjol Ahluwalia. AIR 2005 SC 3180
[878] Nizam's Institute of Medical Sciences v Prasanth S.Dhananka I(1999) CPJ 43(NC)

> Rs.4 lakhs for supplementing the complainant's future earnings and Rs.2 lakhs as compensation for his mental agony, physical suffering and pain and also for physiotherapy, nursing and associated expenses already incurred by him and award of compensation of Rs.1.5 lakhs to the parents for their perpetual mental agony, stress and depression and for the continued support, care and attention they have to provide to the complainant and for the income loss of the mother due to dislocation in her job to look after her son

There is no standard set by any statute or judicial pronouncement for determining amount of compensation in the case of death due to medical negligence. Such standard is available only in the Motor Vehicle Act 1988 by way of application of multiplier provided in the Schedule II.[879]

"Determination of compensation is, a difficult task where no standard or formula is laid down in the statute or in judicial decisions by higher fora or courts", said the State Commission in *Uttam Sarkar v. The Management of Tura Christian Hospital*[880].Moreover, this uncertainty is torturous for those who approach the judiciary for any relief.

Method for calculating compensation in the above discussed cases appears to be compensatory. The major facts which were considered were the cost of recovery, loss of income, including the future income. A serious lack of guidelines exist in respect of calculation of compensation for the death due to negligence of house wives or people who do not have potential income which can be measured in economic terms.In *Lata Wadhwa v. State of Bihar*[881] the Supreme Court held,

> So far as the deceased housewives are concerned, in the absence of any data and as the housewives were not earning any income, attempt has been made to determine the compensation on the basis of services rendered by them to the house. ...This would apply to all those housewives between the age group of 34 to 59 and as such who were active in life.

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[879] Uttam Sarkar v. The Management of Tura Christian Hospital Feb-07-2014.Meghalaya State Consumer Forum. https://www.legalcrystal.com/case/meta/1148488. Last visited on 10-08-2016

[880] *Id*

[881] AIR 2001 SC 3218

In *Savita Garg vs. Director, National Heart Institute*[882] :the court observed that

> the deceased in the instant case is a housewife and we have keenly borne in mind the following illuminating observations of the Apex Court while determining the quantum of compensation while, at the same time, we are deeply conscious of the fact that no amount of money can ever compensate the sudden loss of a precious life and its heart-rending emotional impact on the deceased's family

Similar views were expressed in later decisions also. In 2009, the Court observed:[883]

> Loss of wife to a husband may always be truly compensated by way of mandatory compensation. How one would do it has been baffling the court for a long time. For compensating a husband for loss of his wife, therefore, courts consider the loss of income to the family. It may not be difficult to do when she had been earning. Even otherwise a wife's contribution to the family in terms of money can always be worked out. Every housewife makes contribution to his family. It is capable of being measured on monetary terms although emotional aspect of it cannot be. It depends upon her educational qualification, her own upbringing, status, husband's income, etc

The judicial attitude became clear when the Court expressed in 2010 in *Arun Kumar Agarwal v. National Insurance Company*,[884] "In India, the Courts have recognised that the contribution made by the wife to the house is invaluable and cannot be computed in terms of money. It is not possible to quantify any amount in lieu of the services rendered by the wife/mother to the family." And in *Ramachandrappa v. The Manager, Royal Sundaram Alliance Insurance Company Limited*,[885] it was confirmed :

> The compensation is usually based upon the loss of the claimant's earnings or earning capacity, or upon the loss of particular faculties or members or use of such members, ordinarily in accordance with a definite schedule. The Courts have time and again observed that the compensation to be awarded is not measured by the nature, location or degree of the injury, but rather by the extent or degree of the incapacity resulting from the injury. The tribunals are expected to make an award determining the amount of compensation which should appear to be just, fair and proper.

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[882] AIR 2004 SC 5088
[883] *Malay Kumar Ganguly v Sukumar Mukherjee* (2009) 9 SCC 22
[884] (2010) 9 SCC 218
[885] (2011) 13 SCC 236

In Raj Kumar v. Ajay Kumar, [886] the Supreme Court laid down the following propositions:

> The provision of the motor Vehicles Act, 1988 makes it clear that the award must be just, which means that compensation should, to the extent possible, fully and adequately restore the claimant to the position prior to the accident. The object of awarding damages is to make good the loss suffered as a result of wrong done as far as money can do so, in a fair, reasonable and equitable manner. The court or the tribunal shall have to assess the damages objectively and exclude from consideration any speculation or fancy, though some conjecture with reference to the nature of disability and its consequences, is inevitable. A person is not only to be compensated for the physical injury, but also for the loss which he suffered as a result of such injury. This means that he is to be compensated for his inability to lead a full life, his inability to enjoy those normal amenities which he would have enjoyed but for the injuries, and his inability to earn as much as he used to earn or could have earned.

As per this proposition, the heads under which compensation is awarded in personal injury cases are the following:

- Pecuniary Damages: Expenses relating to treatment, hospitalisation, medicines, transportation, nourishing food, and miscellaneous expenditure.

Loss of Earnings :Expenses which the injured would have made had he not been injured, comprising loss of earning during the period of treatment, loss of future earnings on account of permanent disability, future medical expenses, on-pecuniary damages, damages for pain, suffering and trauma as a consequence of the injuries, loss of amenities and loss of expectation of life.

5.7 REMEDIES UNDER CONSTITUTIONAL LAW

Apart from the remedies available under civil law, the injured party in a, medical negligence has a right to receive remedy under the public law also. Under Article 32 and Article 226, a writ lies to Supreme Court and High Court respectively for the enforcement of right to life under Article 21 of the Indian Constitution. Grant of compensation in writ proceedings as a public law remedy for medical negligence is accepted by various judicial decisions.

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[886] (2011) 1 SCC 343

The distinction between "Public Law" and "Private Law" was considered by a Three-Judge Bench of the Supreme Court in *Common Cause, A Regd. Society v. Union of India & Ors*.[887], in which, it was, observed ,

> Under Article 226 of the Constitution, the High Court has been given the power and jurisdiction to issue appropriate Writs in the nature of Mandamus, Certiorari, Prohibition, Quo-Warranto and Habeas Corpus for the enforcement of Fundamental Rights or for any other purpose. Thus, the High Court has jurisdiction not only to grant relief for the enforcement of Fundamental Rights but also for "any other purpose" which would include the enforcement of public duties by public bodies. So also, the Supreme Court under Article 32 has the jurisdiction to issue prerogative Writs for the enforcement of Fundamental Rights guaranteed to a citizen under the Constitution.

The Public Law remedies have been extended to the realm of tort by the judiciary in various decisions, and have awarded compensation to the petitioners who had suffered personal injuries at the hands of the officers of the Government[888]. Causing of injuries, which amounted to tortious act, was compensated by this Court in many decisions such as *Rudal Sah v. State of Bihar* [889] , *People's Union for Democratic Rights v. State of Bihar*[890], *SAHELI v. Commissioner of Police, Delhi*[891]*etc.* .In *Supreme Court Legal Aid Committee v State Of Bihar,* [892] an application was filed under Article 32 of the Constitution on behalf of the Supreme Court Legal Aid Committee alleging inhumane behaviour meted out to a person. When the passengers of a railway train, where looting had been done by a crowd, had beaten up several persons including the victim. Mahesh had received serious injuries and had to be taken to the hospital for treatment. As no transport was available a rickshaw was hired for the purpose of removing the injured to the hospital. By then the injured had become unconscious. No timely treatment was provided to the injured and he succumbed to death.

The Supreme Court, expressing shock in this incident held that:

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[887] AIR 999 SC 2979
[888] Chairman,Railway Board v. Chandrima Das AIR 2000 SC 988
[889] AIR 1983 SC 1086
[890] AIR 1987 SC 355
[891] 1990 AIR 513,
[892] (1991) 3 SCC 482

> … the compensation of Rs. 20,000/- such a sum is ordinarily paid in the case of death -shall be paid by the State of Bihar to the legal representatives of Mahesh Mahto. The amount shall be deposited with the District Judge, Manger and the District Judge directed to institute a proper inquiry to satisfy himself as to who the heirs of the deceased Mahesh Mahto are. The amount of Rs. 20,000/- shall be paid to them by the District Judge and in case he is of the view that the money should be held in a long term fixed deposit in favour of the rightful heir it is open to him to do so. A compliance report of this direction be furnished to the Registry of this Court within three months

In *Paschim Banga Khet Mazdoor Samiti v. State of West Bengal* [893], disturbing train of events has led to petitioners moving to the apex court with a prayer to protect the right to health, the most important ingredient of right to life. Hakim Seikh, a member of Paschim Banga Khet Mazdoor Samiti, an organization of agricultural labourers, fell off a train and suffered serious head injuries and brain haemorrhage. He was taken to the Primary Health Centre at Mathurapur. Since necessary facilities for treatment were not available, the medical officer in charge of the Centre referred him to the Diamond Harbour Sub-Divisional Hospital or any other State hospital for better treatment. Hakim Seikh was taken to N.R.S. Medical College Hospital. The Emergency Medical Officer in the said Hospital, after examining him recommended immediate admission for further treatment. But Hakim Seikh could not be admitted in the said hospital as no vacant bed was available. He was thereafter taken to Calcutta Medical College Hospital at about 12.20 A.M., but was not admitted for similar reasons. He was then taken to another hospital, and from there referred to a teaching hospital in the ENT, Neuro Surgeon Department on the ground that the hospital has no ENT Emergency or Neuro Emergency Department. He was taken to the Calcutta National Medical College Hospital, but in vain. At last in the Bangur Institute of Neurology, it was found that there was haemorrhage condition in the frontal region of the head and that it was an emergency case which could not be handled in the said Institute. Ultimately he was admitted in Calcutta Medical Research Institute, a private hospital, where he received treatment as an indoor patient and had incurred an expenditure of approximately Rs. 17,000/- in his treatment. Feeling aggrieved by the indifferent and callous attitude on the

[893] AIR 1996 SC 2426

part of the medical authorities at the various State run hospitals in Calcutta in providing treatment for the serious injuries sustained by member of the organization, the petitioners have filed writ petition.

The Supreme Court said,

> In a welfare state the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21....In respect of deprivation of the constitutional rights guaranteed under Part III of the Constitution the position is well settled that adequate compensation can be awarded by the court for such violation by way of redress in proceedings under Articles 32 and 226 of the Constitution.

It was held that, the injured party should be compensated for the breach of his right guaranteed under Article of the Constitution. The amount of compensation was fixed at Rs. 25,000/-. A sum of Rs. 15,000/- was directed to be paid to the injured as interim compensation and the balance amount within one month.

In *Parimal Chakraborty. v. Bijaya Paul* .[894] the learned single Judge while entertaining the Writ Petition regarding claim of compensation for the death of plaintiff's husband due to medical negligence, has awarded a compensation of Rs. 1,00,000/- to the writ petitioner with a direction to recover the said amount from the erring doctors of Kakraban Primary Health Centre after making a formal enquiry. Apart from that medical department was expected to initiate separate disciplinary proceeding against the above two doctors for commission of gross misconduct in attending the patient in Government Primary Health Centre at Kakraban.

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[894] AIR 2007 Gau 72

5.8 REMEDIES UNDER COPRA,1986

With improving awareness and gathering consciousness about one's rights, actions for damages in tort are on the increase. Not only civil suits are filed, complaints filed before Consumer Dispute Redressal Fora also have increased over a period of time. The availability of a forum for grievance redressal under the COPRA, 1986 is widely being used. These Agencies are having jurisdiction to hear complaints against professionals for 'deficiency in service' This expression which is very widely defined in the Act, has given rise to a large number of complaints against professionals, particularly against doctors.[895]

Consumer Protection Act, 1986, being a unique legislation enacted exclusively for the protection of interest of consumers, "meets long felt necessity of protecting the common man from such wrongs for which the remedy under ordinary law has become illusory"[896] The provisions of the Act shall be in addition to and not in derogation of the provisions of any other law for the time being in force.[897]

Section 14, of the Act deals with the power of the forum to grant Redressal. The power to award compensation is included in it.The District Forum if satisfied that any of the allegations contained in the complaint about the services are proved, it shall issue an order to the opposite party directing him to pay such amount as may be awarded by it as compensation to the consumer for any loss or injury suffered by the consumer due to the negligence of the opposite party. Provided that the District Forum shall have the power to grant punitive damages in such circumstances as it deems fit. Further the Forum is empowered to pay such sum as may be determined by it if it is of the opinion that loss or injury has been suffered by a large number of consumers who are not identifiable conveniently. It can also provide for adequate costs to parties. The appellate authorities such as State Commission and National Commission shall also have original jurisdiction with pecuniary limit and shall exercise similar powers.

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[895] *Jacob Mathew* supra note 13
[896] Lucknow Development Authority v.M.K.Gupta AIR 1994SC 787
[897] Section 3 of the Act.

The Supreme Court in *Ghaziabad Development Authority v. Balbir Singh,* [898] it was held that Consumer Protection Act has a wide reach and the State Commission has jurisdiction even in cases of service rendered by statutory and public authorities and such authorities become liable to compensate for misfeasance in public office provided loss or injury is suffered by a citizen. Where there has been negligent exercise or non-exercise of power, the Commission/Forum has a statutory obligation to award compensation.

Therefore as far as medical services are concerned, if deficiency in service is proved, the forum can award compensation, order removal of deficiency in the services and award costs to the plaintiff.

5.8.1 MODE OF ASSESSMENT

The Award of compensation by Consumer Redressal agencies are guided by well-recognized legal principles related to quantification of damages[899].These Fora are duty bound to award compensation on a rational basis. The extent of injury suffered and the monetary loss incurred are assessed on the basis of materials produced before the Forum.[900]The loss is ascertained by balancing various factors. Section 14(1) of the Consumer Protection Act, 1986 deals with Calculation of amount of compensation**.** Under this section, compensation is payable to the consumer for loss or injury suffered due to negligence of the opposite party.

In *Air India v. Suganda Ravishankar,*[901] it was held that the Consumer Forum is not entitled to grant compensation without proof of negligence on the part of the defendant resulting in loss or injury to the complainant.However, in the case of *Hari Bhai Leghar Bhai Solanki v. Dr.Suresh Parikh,*[902]on compassionate grounds compensation was awarded, even though the doctor was found not guilty. The insurance company by which the doctor was covered was asked to pay the amount. In the land mark decision of *Spring Meadows Hospital v.*

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[898] (2004) 5 SCC 65
[899] SINGH & BHUSHAN supra note 761
[900] Commercial Officer,Office of the Telecom District Manager,Patna v. Bihar State warehousing Corporation, 1993(1)CPJ 42
[901] 1993(1) CPJ 63(NC)
[902] 1994(1)CPJ 373(Guj)

Harjol Ahluwalia,[903] the complainant alleged that the minor child on account of negligence and deficiency on the part of the hospital authorities suffered irreparable damages and could survive only as a mere vegetative and accordingly claimed compensation to the tune of Rs. 28 lacs. The Commission came to the finding that there was negligence; error and omission on the part of nurse as well as doctor in rendering their professional services and both of them were negligent in performing their duties. Since the doctor and the nurse were employees of the hospital, the hospital is responsible and liable for their actions. The Commission then determined the quantum of compensation and awarded 12.5 lacs as compensation to the minor patient. In addition to the aforesaid sum of Rs. 12.5 lacs,.The Commission also awarded Rs. 5 lacs as compensation for the acute mental agony that has been caused to the parents by reason of their only son having been reduced to a vegetative state requiring lifelong care and attention.

The Supreme Court held that:

> If the parents of the child having hired the services of the hospital,they are consumer within the meaning of Section 2(1)(d)(ii)and the child also is consumer being a beneficiary of such services hired by his parents in the inclusive definition in Section 2(1)(d) of the Act.The Commission will be fully justified in awarding compensation to both of them for the injury each one of them has sustained. In the case in hand the Commission has awarded compensation in favour of the minor child taking into account the cost of equipment and the recurring expenses that would be necessary for the said minor child who is merely having a vegetative life. The compensation awarded in favour of the parents of the minor child is for their acute mental agony and the lifelong care and attention which the parents would have to bestow on the minor child. The award of compensation in respect of respective consumers is on different head. We see no infirmity with the order of the Commission awarding different amount of compensation on different head, both being consumers under the Act. Accordingly, the Commission in our considered opinion rightly awarded compensation in favour of the parents in addition to the compensation in favour of the minor child.

In *U.K. Kini. v K. Vasudeva Pai And Ors.,*[904] The defendant on examination found that deceased had developed non-toxic adenoma and requires surgery. He

[903] AIR 1998 SC 1801
[904] II (2000) ACC 429, 2001 ACJ 2141

accordingly advised her to undergo surgery. After surgery, plaintiff was shifted to ward in an unconscious state. It is not disputed that the plaintiff did not regain her consciousness till she died on 25.10.1985. However, she was discharged from the nursing home on 6.12.1981.The plaintiffs filed the suit for damages in a sum of Rs. 2, 50,000 /-but confined it only for a sum of Rs. 2, 00,000 /-alleging medical negligence. They have further contended that pre-operative tests required to be done in such type of operations were not conducted. More serious allegations were there, that the consent of the patient or her husband was not obtained in writing even though it was not a case of emergency. Thus defendants have failed to maintain the high standards of professional conduct in dealing with their patient. The High Court held that from the evidence and the pleadings it is clear that the defendants have failed to discharge their duty they owed and thus they are guilty of negligence. The trial court ordered in favour of the plaintiff and accordingly passed a decree for Rs. 2,00,000 apportioning the liability against defendant-the doctor and the hospital in the ratio of 1:3 .upheld by the High Court.

In *Nizam's Institute Of Medical Science v. Prasanth S.Dhananka*,[905] the complainant, then 20 years of age and a student of Engineering, was admitted for the operation and tumour was excised. It appears that immediately after the surgery, the complainant developed acute paraplegia with a complete loss of control over the lower limbs, and some other related complications, which led to prolonged hospitalization .He was completely paralyzed and required continuous physiotherapy and nursing care on account of infection of the urinary tract and the development of bed-sores etc.A complaint was filed before the National Consumer Redressal Commission alleging utter and complete negligence on the part of doctors and also making NIMS vicariously liable and the State of Andhra Pradesh statutorily liable for the negligence of the doctors concerned.

[905] (2009) 6 SCC 1

It was held that there was negligence on the part of defendants and deficiency of service to the Complainant and therefore liable to pay the compensation. The Court said,

> We feel that the items mentioned under this category such as regular dressing material, bags and tape for urine drainage, cotton rolls for defecation, material for loin clean up and treatment, dressing, nursing services including cleaning, giving bath, bed sores etc. physiotherapy and extra nourishment are necessary and allowable. …. Regarding the compensation claimed on account of loss of future earnings, we realize that the incident has severely affected the career of the complainant which, as seen from his academic record prior to the operation, would have been a good one otherwise….We also perceive the anxiety, agony and distress of the parents on the condition of the complainant consequent to the operation. It is stated in the complaint that the Complainant's mother had to give up her teaching job in a school so as to look after the Complainant who is totally bred-ridden and requires round the clock assistance and attention. It has also been stated that complainant's brother was mentally upset which affected his performance in his examination and resulted in securing admission in a college by paying huge fee. Further, the complainant's maternal uncle had to supplement the physical efforts of his parents in attending on the complainant and also bring food to the hospital even on curfew-bound days with great difficulty. In short, the entire family was put in disarray.

The Court has explained the method by which the amount of compensation was arrived at:

> While determining the compensation to the complainant as also to his parents, we have kept in view the broad parameters followed by us in an earlier case of medical negligence … we are of the view that the facts and circumstances of the case justify (i) the award to the complainant of an amount of (a) Rs.8 lakhs (expected to yield a monthly interest of about Rs.8,000/-) towards prospective charges for physiotherapy, nursing and associated expenses, (b) Rs.4 lakhs (expected to yield a monthly interest of about Rs.4,000/-) for supplementing the complainant's future earnings and (c) Rs.2 lakhs as compensation for his mental agony, physical suffering and pain and also for physiotherapy, nursing and associated expenses already incurred by him and ii) award of compensation of Rs.1.5 lakhs to the parents for their perpetual mental agony, stress and depression and for the continued support, care and attention they have to provide to the complainant and for the income loss of the mother due to dislocation in her job to look after her son.

Regarding ‘adequate compensation’ the Court observed that,

> We must emphasize that the Court has to strike a balance between the inflated and unreasonable demands of a victim and the equally untenable claim of the opposite party saying that nothing is payable. Sympathy for the victim does not, and should not, come in the way of making a correct assessment, but if a case is made out, and the Court must not be chary of awarding adequate compensation. The "adequate compensation" that we speak of, must to some extent, be a rule of the thumb measure, and as a balance has to be struck, it would be difficult to satisfy all the parties concerned. It must also be borne in mind that life has its pitfalls and is not smooth sailing all along the way (as a claimant would have us believe) as the hiccups that invariably come about cannot be visualized. Life it is said is akin to a ride on a roller coaster where a meteoric rise is often followed by an equally spectacular fall, and the distance between the two (as in this very case) is a minute or a yard. At the same time we often find that a person injured in an accident leaves his family in greater distress, vis-`a-vis a family in a case of death. In the latter case, the initial shock gives way to a feeling of resignation and acceptance, and in time, compels the family to move on. The case of an injured and disabled person is, however, more pitiable and the feeling of hurt, helplessness, despair and often destitution endures every day. The support that is needed by a severely handicapped person comes at an enormous price, physical, financial and emotional, not only on the victim but even more so on his family and attendants and the stress saps their energy and destroys their equanimity. We can also visualize the anxiety of the complainant and his parents for the future after the latter, as must all of us, inevitably fade away. We, have, therefore computed the compensation keeping in mind that his brilliant career has been cut short and there is, as of now, no possibility of improvement in his condition, the compensation will ensure a steady and reasonable income to him for a time when he is unable to earn for himself.

In *Arvind Kumar Mishra v. New India Assurance Co. Ltd. and another,*[906] the Court sought to assess future earnings of a final year engineering student who received injuries to the brain among others which resulted in 70% permanent disability and he needed a helper throughout his life. It was observed:

> We do not intend to review in detail state of authorities in relation to assessment of all damages for personal injury. Suffice it to say that the basis of assessment of all damages for personal injury is compensation. The whole idea is to put the claimant in the same position as he was in so far as money can. Perfect compensation is hardly possible but one has to keep in mind that the victim has done no wrong; he has suffered at the hands of the wrongdoer and the court must take care to give him full and fair compensation for that he had suffered. In some cases for personal injury, the claim could be in respect of life time's earnings lost

[906] (2010) 10 SCC 254

> because, though he will live, he cannot earn his living. In others, the claim may be made for partial loss of earnings. Each case has to be considered in the light of its own facts and at the end, one must ask whether the sum awarded is a fair and reasonable sum.

In *Kusum Sharma and others v. Batra Hospital & Medical Research Centre and others,*[907]the apex court has expressed its reservations in this area. Complaint was filed under section 21 of the Consumer Protection Act, 1986 claiming compensation of Rs.45 lakhs attributing deficiency in services and medical negligence in the treatment of the deceased. Upholding the order passed by the National Commission, the Supreme Court observed that,

> It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessary harassed or humiliated so that they can perform their professional duties without fear and apprehension.…The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurizing the medical professionals/hospitals particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners… The interest and welfare of the patients have to be paramount for the medical professionals.

In *Dr.Rama Hegde v Ningappa* [908], wife of the respondent who was in advance stage of pregnancy was examined by the petitioner. After conducting the blood test and scanning informed the respondent that the normal delivery is not possible and caesarean has to be conducted. On the consent given by the respondent, operation was conducted, which was successful and the patient was shifted to the ward on the same day. The mother and new born child were very healthy. Later, the patient was complaining about some abdominal distension and there was some septicaemia. She was administered Glucose and other medicines through blood veins. Thereafter, she has recovered and she started taking food orally. When the dressing of the operated portion was opened, it was found that there was puss formation and the same was cleaned and again dressing was made. The relatives of patient requested the petitioner to discharge

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[907] (2010) 3 SCC480 (7)

[908] Writ petition number 65704/2009 (GM-CON)1st day of August, 2013, High Court of Karnataka,Circuit Bench,Dharwad. http://judgmenthck.kar.nic.in/judgments/bitstream/123456789/896471/1/WP65704-09-01-08-2013.pdf. Last visited on 17-08-2016 at 14.45

her from the said hospital to take her to KIMS Hospital at Hubli for better treatment. On their request, Ambulance arrangement was also made by the petitioner. Subsequently, she died at KIMS Hospital on .The respondent filed a complaint before District Forum for deficiency of service, alleging medical negligence.

The specific case of the petitioner is that death of the respondent's wife is not due to the medical negligence; on the other hand, death was due to septicaemia. She died 25 days after the caesarean, for which, the petitioner cannot be held responsible. Apart from that, the medical Officer who is employed in a Government Hospital renders service on behalf of the Government at free of charge. The services rendered in Government Hospital do not fall within the ambit of Section 2(1)(o) of the Act.

The District Forum without considering any of the contentions raised by the petitioner, gave direction to the petitioner herein to pay Rs.50,000/- as compensation towards deficiency in service and mental agony to the complainant with interest at the rate of 6% and the cost of litigation. Being aggrieved by the order passed by the District Forum, the petitioner filed an appeal before the State Commission. The State Commission without critically examining the contention of the petitioner dismissed the appeal confirming the order passed by the District Forum holding that the material placed by both the parties clearly discloses that there is deficiency in service. Being aggrieved by the order passed by the State Commission as well as the District Forum, the petitioner has filed this writ petition before the High Court.The Court held that, " …the petitioner has got statutory and efficacious remedy under Section 19 of the Act[909]. Hence, the writ petition filed by the petitioner is not maintainable and he has to avail the remedy under the Act."

[909] Section 19:Any person aggrieved by an order made by the State Commission may prefer an appeal against such order to the National Commission within a period of thirty days from the date of the order in such form and manner as may be prescribed:

Balram Prasad v. Kunal Saha & Ors[910]

"I cannot say I'm pleased with the quantum of compensation after spending so much money to fight this legal battle, but this fight was never for money. The verdict has sent the right message to the medical community in India."[911]

These words are relevant not only because it talks volumes on the difficulties, one will have to face in fighting medical negligence in India, but more importantly it resurges important questions on the purpose of awarding compensation in such cases.

In the above mentioned case, Supreme Court ordered the AMRI Hospital in Kolkata and three doctors to pay Rs 60 800 000 /-plus interest in compensation to Indian-American doctor Kunal Saha for medical negligence that led to the death of his wife, Anuradha, aged 36, in 1998. This is the highest compensation ordered by the apex court of India in a case relating to medical negligence. The event occurred when the patient came to Kolkata from the United States for a vacation and consulted Dr. Sukumar Mukherjee after developing skin rashes. Mukherjee did not prescribe any medicines and asked her only to take rest. The rashes intensified in May and Mukherjee then prescribed injections, a step later faulted by experts. However, patient's condition worsened and she was admitted to AMRI Hospital under Mukherjee's care. When matters worsened, she was flown to Mumbai where she was admitted to Breach Candy Hospital where she died.[912] The claimant filed Original Petition in 1999 before the National Commission claiming compensation for Rs.77,07,45,000/- and later the same was amended by claiming another sum of Rs.20,00,00,000/-.The National Commission held the doctors and the AMRI Hospital negligent in treating the wife of the claimant on account of which she died. However, the claimant, the defendant hospital and the doctors were aggrieved by the amount of compensation awarded by the National Commission and also the manner in

[910] (2014) 1 SCC 384
[911] Nivedita Choudhuri, *Record damages are awarded in medical negligence case in India*, BMJ 2013; 347:f6551. (Last visited on 8-10-2016 at 19.38) http://www.bmj.com/content/347/bmj.f6551. (News published on October 30th 2013)
[912] *Id*

which liability was apportioned amongst each of them. While the claimant was aggrieved by the inadequate amount of compensation, the appellant-doctors and the Hospital found the amount to be excessive and too harsh. They further claimed that the proportion of liability ascertained on each of them is unreasonable.[913]

5.8.2 REMEDY: ONLY COMPENSATORY?

As far as, medical negligence is concerned, there are specific factors which makes it non-comparable with other forms of negligence, particularly that of motor vehicle accidents. It requires a separate treatment because, it effects the rights of the patients who approach doctors, nursing homes and other similar establishments, spending all their money with the hope to live a better healthy life .The patients irrespective of their social, cultural and economic background are entitled to be treated with dignity which not only forms their human right but fundamental right also. This is not the case of a victim of other form of negligence, even though; there is certainly a violation of right which demands reparation.

The purpose of remedy in medical negligence, no doubt, is compensating the loss in pecuniary terms. However, is it the only function? Is it not expected to prevent such mishaps in future? Regarding the preventive function, the question arises how we can deter? Unlike traditional torts like battery or assault, negligence lacks a wrongful intention. Rather it stems from an absence of application of mind. It is an omission to take care. A wrongful absence of sense of duty.Inorder to deter a potential wrong doer, the compensation should be something which the person wants to avoid at any cost. It should be an incentive to a person for being delegent.Do the practices of compensating medical negligence in India does that job?

Private health care services in India have grown rapidly to meet rising expectations and incomes. Surveys indicate that 75% of human resources and advanced medical technology and 68% of hospitals are provided by the private sector. Around 90% of dentists and 80% of practitioners of ayurveda, yoga and

[913] (2014) 1 SCC 384

naturopathy, unani, siddha and homeopathy (AYUSH) are also in the private sector[914]. The private sector has world class facilities and high end marketing strategies. Health care has emerged as the most lucrative industry along with a wide scope for medical tourism. The power-both political and economic- put health care professional , in a position almost near to impunity.

Medical negligence liability is needed not just to induce patient specific, post-action investments; it is also needed to induce physicians to invest in measures –such as expertise and equipment – whose benefits are collective and durable. They should reduce the risk of error for both existing and future patients. To provide optimal incentives, liability must ensure improved quality care that is the result of a conscious and collective attempt. Its benefits extend to future patients[915]

In *Kunal Saha's*, [916] loss of income had been a significant criterion in determining the amount of compensation. The victim being a young lady with a good potential income was the single factor that made the damages huge. Therefore, the amount is not comparable. It changes, largely according to the age, earning capacity and socio-economic status. Standards are uncertain, rather absent, when it comes to victims who do not earn or earn insignificantly. The amount of compensation awarded was arrived at by calculating the prospective loss of income for the wrongful death of claimant's wife based on her future potential in the U.S.A. by an economic expert. This was a weighty factor in the amount being the highest ever granted by a court of law in India in such cases. But imagining that the victim was poor house wife of a daily wage worker with

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[914] Isabelle Joumard and Ankit Kumar, Improving Health Outcomes And Health Care In India Economics Department Working Papers No. 1184, OECD Working Papers (Economics Department).(January2015) http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=ECO/WKP(2015)2&docLanguage=En. Last visited on 13-10-2016 at 12.52

[915] Aditya Singhal, The Veracity of Laws relating to Medical Malpractice in India Scope and Nature,Monograph,Publishing Partner- International Journal of Scientific and Research Publications. http://www.ijsrp.org/monograph/Veracity_of_laws_relating_to_medical_malpractice_in_India.pdf. Last visited on 17-08-2016 at 11.20

[916] (2014) 1 SCC 384 supra note 910

nominal academic qualifications, the amount would have been some mere thousands.

Arithmetical allocation of compensation satisfies the concept of corrective Justice. But from a socialistic angle, how the equilibrium can be maintained when the initial distribution of resources is not just? It does not do justice, when the allocation is among a mighty professional and a poor worker, an influential establishment and an insignificant woman or a strong doctor and a delicate patient.

In *Sarla Verma's case*[917] the Court, held that the multiplier method is the proper and best method for computation of compensation as there will be uniformity and consistency in the decisions. The said view has been reaffirmed in ***Reshma Kumari. v. Madan Mohan*** [918].

> ….. "just Compensation" is adequate compensation which is fair and equitable, on the facts and circumstances of the case, to make good the loss suffered as a result of the wrong, as far as money can do so, by applying the well-settled principles relating to award of compensation. It is not intended to be a bonanza, largesse or source of profit. [919]

Justice emanate from equality in treatment, consistency and thoroughness in adjudication, and fairness and uniformity in the decision-making process. While it may not be possible to have mathematical precision or identical awards in assessing compensation, same or similar facts should lead to awards in the same range. Consistency and uniformity should be the result of adjudication[920].

The methods of computation used in motor accidents cannot be used in medical negligence. In a motor accident, how much ever, the driver is negligent; he has no idea about the victim of his recklessness. That means, his behaviour is not affected by the socio-economic and political background of the victim. In other words, the increase or decrease in amount of compensation linked to the social position of the victim will not influence his behaviour. On the other hand, a doctor or a hospital gets a clear idea about the socio-economic background of

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[917] Sarla Verma v. Delhi Transport Corporation (2009) 6 SCC 121
[918] (2013) 9 SCC 65
[919] *Sarla Verma* supra note 916
[920] (2014) 1 SCC 384

patient. Therefore, this factor can influence the care in the treatment or the lack of it.At this point of time 'intention' creeps into negligence, since, he has a choice to be negligent or not. It is dangerously associated with the victim's position.Therfore, if the potential income or loss of income is the determining factor in calculating compensation in medical negligence, it can be counter-productive in current Indian socio-economic profile.

In civil law, compensatory damages are the primary monetary remedy, awarded on the basis of the loss or injury to the plaintiff, rather than on the basis of the defendant's fault. The common law has, however, long made provision for the award of non-compensatory damages. These have been variously described as punitive, exemplary, aggravated, vindictive, or retributive.[921] The place of these damages, in a civil law that is ostensibly purely compensatory, has always been precarious, and they have often been criticised as anomalous.[922] Non-compensatory damages exist on the boundary between the civil and the criminal law, and appear to import elements of the criminal law.[923] . The primary purpose of an award of exemplary damages may be deterrent, or punitive and retributory; and the award may also have an important function in vindicating the rights of the plaintiff. The award signals to the defendant that "tort does not pay"[924] and at the same time it vindicates the rights of the plaintiff and the strength of the law. Subjected to a closer analysis, the distinction between the compensatory and punitive purposes of monetary sanctions is difficult to distinguish. It is argued that a monetary award for the loss of a limb cannot in any real sense compensate for the loss. And the real purpose of the award of compensatory damages is "to put the plaintiff in possession of a sum of money which in the court's judgment ought to be enough to satisfy his vindictive

[921] Atcheson v Everitt, 98 Eng. Rep. 1142, 1147 (27 K.B.1775),See, Consultation Paper on Aggravated, Exemplary And Restitutionary Damages, The Law Reform Commission,Ireland,April,1998,pp 3-20.Available at: http://www.lawreform.ie/_fileupload/consultation%20papers/cpAggravatedDamages.htm
[922] Fay v Parker, 53 N. H. 342 (1873) at p.382.
[923] *Id*
[924] Rookes v Barnard [1964] AC 1129), Consultation Paper on Aggravated, Exemplary And Restitutionary Damages, The Law Reform Commission,Ireland,April,1998,pp 3-20.Available at: http://www.lawreform.ie/_fileupload/consultation%20papers/cpAggravatedDamages.htm.

feelings against the wrongdoer."[925] Lord Hope said, 'The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached.'[926] It is agreed that the basic purpose of tort damages is to compensate for the loss of the plaintiff. But in *Blake*, the House of Lords acknowledged that English 'law does not adhere slavishly to the concept of compensation for financially measurable loss': Damages may be measured by the gain made by the defendant.[927]There exist a controversy regarding the true nature of such damages. Gain-based damages are considered by some as restitutionary and compensatory by some others. The better view is that these damages are vindicatory in nature. Vindicatory damages, which to date have only been explicitly recognised in public law, are neither loss-based nor gain-based: they are a rights-based remedy.[928]It is this function that a remedy must also do while compensating medical negligence. As it was held in *Ghaziabad Development Authority*.[929]

> The Commission/Forum can determine the amount for which the authority is liable to compensate the consumer. Such compensation is for vindicating the strength of the law. It acts as a check on arbitrary and capricious exercise of power. It helps in curing social evil. It will hopefully result in improving the work culture and in changing the outlook...

5.9 CONCLUSION

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[925] *Id*, See ,J.M.Kelly,*The Malicious Injuries Code and the Constitution,The Irish Jurist,*Vol.$,New Series(NS)221.See also,POUL WARD,TORT LAW IN IRELAND. https://books.google.co.in/books?id=OtPwqlDHdiQC&pg=PA37&lpg=PA37&dq=j.m+kelly+purpose+of+awarding+compensation&source=bl&ots=ZAAjDznI8I&sig=wrIVnE7qjimYFUq6Ykbyf_ri1eY&hl=en&sa=X&ved=0ahUKEwig_u7Bw8vPAhVCMY8KHcM1C_0Q6AEIGzAA#v=onepage&q=j.m%20kelly%20purpose%20of%20awarding%20compensation&f=false (E-book,Last visited on 8-10-2016 at 21.22)

[926] Chester v. Afshar [2004] UKHL 41; [2005] 1 A.C. 134 at para. 87 See, David Pearce and Roger Halson, *Damages For Breach Of Contract: Compensation, Restitution, And Vindication*, Oxford Journal of Legal Studies (2007), http://eprints.whiterose.ac.uk/3518 Last visited on 8-10-2016 at 21.56

[927] A.G. v. Blake [2001] 1 A.C 268 See David Pearce and Roger Halson, *Damages for Breach Of Contract: Compensation, Restitution, and Vindication*, Oxford Journal of Legal Studies (2007), http://eprints.whiterose.ac.uk/3518 Last visited on 8-10-2016 at 21.56.

[928] David Pearce and Roger Halson, *Damages For Breach Of Contract: Compensation, Restitution, And Vindication*, Oxford Journal of Legal Studies (2007), http://eprints.whiterose.ac.uk/3518 Last visited on 8-10-2016 at 21.56

[929] (2004) 5 SCC 65

The primary nature –lack of care –of deficient medical service can be originated from the disadvantaged position of victim. It makes the wrong different and therefore demands separate treatment.

While awarding costs, a conservative approach has been adopted by Consumer Fora[930].Calculating the potential income of the victim is not always advisable. This may encourage the wrongdoer to have different standards of duty of care to different people, based on their social position. Compensation is not possible in many cases as the loss is not computable in monetary terms. Undoubtedly remedy should compensate, but it should also vindicate the rights of the victim. In appropriate cases the amount of compensation awarded should be commensurate with the loss and injury suffered by the complainant / respondent. In addition, the provision relating to punitive damages need to be utilized in public interest[931].The method of computing damages needs to have components satisfying both-compensation and prevention-functions of remedy.

In order to ensure consistency and uniformity, award of compensation needs to have clear and certain standards. With respect to medical negligence, it is absent in India. It is a serious infirmity which is certain to affect basic rights of people in galore. A comprehensive legislation, in the lines of Motor Vehicles Act, 1988, exclusively dealing with deficiency in medical service is an urgent need.

In the words of Friedman, function of the law is to lay down certain standards of conduct which the community is expected to observe since without the observation of such standards civilised life could not be carried on satisfactorily[932]. This is termed as the social purpose of the law of torts .It is essential that the damages awarded in the medical negligence cases gives the right message to the medical community that ‘ tort does not pay’ irrespective of

[930] Report Of The Working Group On Consumer Protection 19-20 Twelfth Plan (2012-17) Volume - Ii Subgroup Report Government Of India Department Of Consumer Affairs Ministry Of Consumer Affairs, Food And Public Distribution. Http://Planningcommission.Gov.In/Aboutus/Committee/Wrkgrp12/Pp/Wg_Cp2.Pdf

[931] *Id*

[932] Friedman, *Punitive Damages in Tort* 48 Can Bar Rev 373 (1970).

the social status of the victim. In setting that lies the protection of patients in India.

Chapter VI
Conclusion

CHAPTER VI CONCLUSION

It is clearly established that in India, Consumer Protection Act,1986 gives the best remedy available for deficiency in medical service generally and specifically in surgical care. But the dispute is on how far or how limited is the access of this legislation. And how expeditious this remedy is actually reaching the people to whom it intended to reach.

COPRA, 1986 was passed with high hopes. India was the first country to enact legislation, immediately after the United Nations came up with the model. The apparent objectives of the Act include providing the right to get consumer education. This statute has shouldered central/state governments, responsibility to set up Consumer Protection Council, which will work towards achieving the declared objectives. It establishes a three tyre system of Redressal Agencies which will provide economic, expeditious and effective remedy with a rather informal approach.

Ever since *Indian medical Association case*[933]settled that 'medical service 'is 'service' under COPRA, The Consumer Courts are being depicted as the solace for a party injured by the negligence of a doctor. Number of medical litigations is increasing. More issues are gaining significance on medical mal-practice including vitiated consent, defensive medicine, product liability, compensation etc. But the most critical question is, 'does the current system of consumer protection is equipped enough to fight against deficiency in medical services? This study has mainly focused on analysing the data on, law and practice of Medical negligence and Consumer Protection in India, other legislation in the health sector, legal position in other countries-mainly US and UK and some Common Law jurisdictions, judge made laws in India as well as abroad, data collected by earlier researchers etc. In the process the following observations were made.

While Consumer Protection legislation is a driving force for compliance of quality standards for manufacturers, retailers and service providers, there is a

[933] *IMA* supra note 527

vast difference in their influence across region and across services. Informed citizenry is the prime mover of implementation of any law, the absence of which will slacken such a movement. In India –in any part of the world for that matter- a patient is a delicate human being. He is down not only physically but there is a set back at mental and emotional level also. This is the critical concern one should have before looking into medical malpractice liability. Considering the social, financial and economic status of a medical practitioner, the patient is vulnerable –irrespective of his economic status. Therefore, the arithmetic allocation- the reversal of wrongful changes to an initial distribution of resources.-will not give fair result. The glaring facts about medical practitioner's civil liability in India are follows.

- COPRA, 1986 gives easy and economic accessibility to judicial forums and expeditious remedy.
- The current legal position establishes that 'medical service' is 'service' under COPRA.
- Consumer Fora established under the Act are capable to decide matters relating to Deficiency in Medical Service.
- Generally, like in any other civil suit, the burden of proof is with the complainant.
- Principles of Tort Law such as, *res ipsa loquitur*, vicarious liability, are applicable in such cases.
- Unless it is necessary, expert evidence is not the rule.
- The doctor is not negligent; if he follows methods which are accepted by professional body of medical men. But reasonability is always subject to judicial review.
- Medical interference without consent is considered to be deficiency in service. However, disclosure of information can be subjective to the physician's point of view.
- COPRA, 1986 is the best available remedy for Deficient Medical Services

Studies suggest that, awareness among Indian population about the Consumer rights is remarkably low. It is true that information only will not emancipate the

injured party to move to court and demand justice. There are other factors such as accessibility and satisfactory functioning of the adjudicatory mechanism, absence of delay, finality of decisions and certainty of relief. But information about the available rights is a pre-requisite.

As per the National Health Profile 2015 published by the Ministry of Health and Family affairs, in India 25.96% of the population is illiterate [934] According to the estimate 25.7% of rural and 13.7%of urban population live below poverty line. The report says that there is a persistent inequality in health status between and within states due to various economic and social causes. The share of centre in total public expenditure on health is declining steadily over the years. The public spending on health in India, as a percentage of GDP, is one of the lowest among South-East Asian countries and the lowest among Brazil, Russia, India and China (BRIC nations).[935]

> In India, majority of citizens requiring medical care and treatment fall below the poverty line. Most of them are illiterate or semi-literate. They cannot comprehend medical terms, concepts, and treatment procedures. They cannot understand the functions of various organs or the effect of removal of such organs. They do not have access to effective but costly diagnostic procedures. Poor patients lying in the corridors of hospitals after admission for want of beds or patients waiting for days on the roadside for an admission or a mere examination is a common sight. For them, any treatment with reference to rough and ready diagnosis based on their outward symptoms and doctor's experience or intuition is acceptable and welcome so long as it is free or cheap; and whatever the doctor decides as being in their interest, is usually unquestioningly accepted. They are a passive, ignorant and uninvolved in treatment procedures. The poor and needy face a hostile medical environment - inadequacy in the number of hospitals and beds, non-availability of adequate treatment facilities, utter lack of qualitative treatment, corruption, callousness and apathy. Many poor patients with serious ailments (eg. heart patients and cancer patients) have to wait for months for their turn even for diagnosis, and due to limited treatment facilities, many die even before their turn comes for treatment. What choice do these poor patients have? Any treatment of whatever degree is a boon or a favour, for them. The stark reality is that for a vast majority in the country, the concepts of informed consent or any form of consent, and choice in treatment, have no meaning or relevance.

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[934] National Health Profile-2015 supra note 501
[935] *Id*

This is the reflection of Indian Supreme Court in 2008.[936].Situation has not changed much even after 8 years.

There is new-generation medical consumer emerging. Since they are tech and net savvy, information is readily available for them. But the dependability on the doctor or the hegemony of his fellow men never diminishes. The doctor may no longer be considered as 'God' but his relationship with the patient is still fiduciary.

> Remarkable developments in the field of medicine might have revolutionized health care. But they cannot be afforded by the common man. The woes of non-affording patients have in no way decreased. Gone are the days when any patient could go to a neighbourhood general practitioner or a family doctor and get affordable treatment at a very reasonable cost, with affection, care and concern. Their noble tribe is dwindling. Every Doctor wants to be a specialist. The proliferation of specialists and super specialists, have exhausted many a patient both financially and physically, by having to move from doctor to doctor, in search of the appropriate specialist who can identify the problem and provide treatment. What used to be competent treatment by one General Practitioner has now become multi-pronged treatment by several specialists.[937]"

In medical malpractice cases, the consumer is in a more delicate situation were in the material evidence which he need to produce for proving the case, is many times in the custody of the doctor or the hospital. He needs to rely on the legal system to obtain them in order to even initiate a legal action. In case of surgery, it involves use of such intricate technology, specialist skills and thorough technical knowledge.it becomes impossible for a layman to determine, 'who is at fault?' These are some of the many problems which an average medical litigant is facing in practical life. There are many more critical hurdles, very much part of the system which he needs to overcome in winning a legal battle.

> There is a general perception among the middle class public that these private hospitals and doctors prescribe avoidable costly diagnostic procedures and medicines, and subject them to unwanted surgical procedures, for financial gain. The public feel that many doctors who have spent a crore or more for becoming a specialist, or nursing homes which have invested several crores on diagnostic and infrastructure facilities, would necessarily operate with a purely commercial and not service motive; that such doctors and hospitals would advise extensive

[936] *Sameera Kohli*. supra note 936
[937] *Id*

> costly treatment procedures and surgeries, where conservative or simple treatment may meet the need; and that what used to be a noble service oriented profession is slowly but steadily converting into purely a business[938].

This study has focused on Deficiency in Surgical Treatment and it revealed the following facts:

- Medical Negligence is Deficiency in Service. However Deficiency in Medical Service is a wider connotation, which includes actions, not necessarily negligent.
- Surgery is a form of medical interference which requires specialist skills.
- The surgeon is not expected to cure, but to exercise the reasonable diligence and high standard of knowledge which he professes.
- Indian Courts and Consumer Fora have accepted that any kind of surgery involves risk.
- Lack of preparation before performing surgery is held to be deficiency in service.
- Not conducting proper diagnosis is negligence, but practice of defensive medicine will also amount to deficiency.
- Duty of surgeon extends to post-operative care.Threfore discharging the patient without clear instructions for continued care will amount to negligence.
- Abandoning a patient after surgery is deficiency in service.
- The Courts in India follow the methods of law of Tort in assessing and awarding compensation.
- Indian Courts still follow Bolam principle for fixing medical negligence liability, a principle which has been watered down, if not abandoned by *Bolitho*[939]*,Chester*[940] *and Montgomery*[941] decisions in its birth place.
- Informed consent from the patient's perspective is still not the law in India

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[938] *Sameera Kohli* supra note 936
[939] supra note 91
[940] supra note 455
[941] supra note 460

- There are no clear standards set in COPRA regarding the quantum of compensation .In each case the amount is determined by taking into various aspects, which need not be uniform or constant.
- Consumer Redressal agencies, envisaged as speedier and effective alternative to Civil Courts have become another form of the latter with the avoidable formal approach.
- In these adjudicatory bodies which is conceived as informal agencies for informal one to one interaction, ubiquitous presence of advocates is noticed.
- The time limit of 60-120 days for passing an order is hardly observed.
- There is a frustrating delay in adjudication before these Fora.
- The well-intended appeal provisions are used by mighty defendant to swindle the system and stag the matter.
- There is lack of enthusiasm on the part of the state governments in setting up and functioning of Consumer Protection Councils
- The Adjudicatory bodies are poorly manned and inadequately equipped.
- Major attempts are required to create awareness among the population about Consumer Rights.
- Establishment and working of Consumer Fora is influenced by the Human right atmosphere-social, economic, educational disparities-.Lack of awareness about the Consumer Rights is major hurdle in implementation of this magnificent piece of legislation.
- The large majority of Indian Population still has no accessibility to the protection of COPRA, 1986 since the medical services provided by Government hospital are out of the purview of Consumer Protection Act,1986

In order to invigorate the consumer protection in India, the following changes are suggested.They are divided in to two.Part A and Part B.

Part A consist of general suggestion. The Thesis is having a specific suggestion to enact new law and establish a new set of adjudicatory mechanism which will be free from the infirmities of COPRA.Part B contains the draft legislation.

Part.A.General Suggestions

- The concept medical negligence has gone long way from *Bolam* principle. Changes are required in the legal provisions to define this civil wrong more clearly, as per the changing times.
- The principle of 'real consent' is no longer acceptable even in England. It is high time we moved towards the Canterbury principle of informed consent.
- The right to choose is a far cry as far as medical consumer is concerned. State funding as well as private investment has to be encouraged in this sector so as to have competition regime in operation.
- Since awareness is a major pre-requisite for empowerment of consumers, serious attempts are necessary in this direction. Consumer protection Councils must be invigorated in this direction.
- The right to consumer education needs to be materialised through effective and transparent channels.
- There is a need for clear guidelines on calculation of damages in case of Deficient Medical Service.
- Courts in India, maintain the stand that purpose COPRA is to compensate. But in specific cases like deficient medical services, vindication of patient's right is very important. Since the victim's socio-economic background is known to the wrong doer unlike other kind of negligence, remedy should not be only compensatory, it must be punitive too.

Part.B. Salient features and Draft of the model legislation

The following are the salient features of the legislation.

- The Protection from Deficiency in Medical Services Act will be in the model of COPRA
- The objective of the Act will be to provide speedy and economic remedy for Deficiency in Medical Service to all citizen and to establish health tribunals for that purpose.
- The term 'patient' and 'injured party' will be defined instead of 'consumer' and 'complainant'.

- It will establish ‘ Health Tribunals’ in place of Consumer Redressal Agencies.
- The jurisdiction will be territorial and based on the number of population in the respective area.
- Appellate Tribunals will not have original jurisdiction.
- In general, Health Appellate Tribunal shall be the final court of appeal.
- Appeal to National Appellate Tribunal is subject to the leave of the Tribunal. Appeal is limited to only those cases having substantial question of law. This is to control the unnecessary appeals and unending delay.
- A responsibility will be cast on the state /central government to establish this tribunal and recruit its personnel, which will be right in the hands of citizen. There will be regular check on the functioning for which the respective governments shall be responsible.
- Specific provisions are incorporated to fix the compensation for Deficiency in Medical Service. Apart from the damages which will be calculated on the basis of well-established principles, a particular percentage of the income of the practitioner/hospital will be mandatorily paid to the victim in case of any proven deficiency.

THE PROTECTION FROM DEFICIENCY IN MEDICAL SERVICES ACT, 2016

[An Act to provide for better protection of the interests of patients from medical negligence and for that purpose to make provision for the establishment of adjudicatory authorities for the settlement of disputes and for matters connected therewith.]

Whereas it is expedient to regulate deficiency in medical services provided in the country both in public and private sector.

And whereas Parliament has no power to legislate for the states in the above mentioned area except as provided in Article 249 and 250 of the Constitution.

And whereas in pursuance of clause (1) of Article 252 of the Constitution, resolutions have been passed in the legislatures of the states to the effect that matters aforesaid should be regulated by Parliament by law.

BE it enacted by Parliament in the Sixty-seventh Year of the Republic of India as follows:—

CHAPTER I

Preliminary

1. Short title, extent, commencement and application.—

    1) This Act may be called the Protection From Deficiency in Medical Services Act,2016
        a. It extends to the whole of India except the State of Jammu and Kashmir.
        b. It shall come into force on such date as the Central Government may, by notification, appoint and different dates may be appointed for different States and for different provisions of this Act.
        c. Save as otherwise expressly provided by the Central Government by notification, this Act shall apply to all medical services.

2. Definitions.—

(1) In this Act, unless the context otherwise requires,—

a. Patient means; any person availing medical services under any law existing in India.

b. Medical Service means; Services of any description made available to a patient through a Registered Health Care Provider or a hospital, nursing home, clinic or health centre (Private or public) or any other place within the purview of 'clinical establishment' under the Clinical Establishments Act, 2010 or health camp organized with due permission from the authorities (by government or Private bodies) and includes services provided by Physiotherapist and a practitioner of alternate medicine.

c. Registered Health Care provider means;

   i. a person having qualifications prescribed by the Indian Medical Council Act, 1956 and whose name is registered in the register under the Act

   ii. any practitioner of Ayurveda,Unani,Siddha or any other as defined in Indian Medicine Central Council Act,1970 and whose name is entered in the State Register or Central Register of Indian Medicine

   iii. any person who is recognized under Homeopathic Central Council Act,1973 and having his name registered in the central or state register

   iv. any nurse or midwife having recognized under Indian Nursing Council Act,1947 and having their name registered in the Indian Nursing Register or State Register

   v. Any Recognized Dentist under Indian Dentist's Act,1948 and having his name registered in the central or state register

d. Deficiency in Medical Service means; means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance including absence of informed consent,

which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed in relation to any medical service.

Whereas informed consent under this provision would mean consent obtained by furnishing the kind of information which a reasonable patient or his dear and near, in similar circumstance would require to be able to take a balance decision.

e. Grievance means; any allegation in writing made by a patient that the medical services availed by him suffer from deficiency in any respect
f. Injured party means— a patient; or

(ii) any voluntary association registered under any other law for the time being in force; or

(iii) the Central Government or any State Government,

(iv) one or more patients, where there are numerous patients having the same interest;

(v) in case of death of a patient, his legal heir or representative;

g. Health Tribunal means; adjudicatory bodies established under this Act.
h. Terms such as, 'persons having judicial background', 'prescribed', 'member', 'person' 'notification' shall have the same meaning as that in Consumer Protection Act,1986

CHAPTER II

Health Tribunals

3. Establishment of Health Tribunals: There shall be established for the purposes of this Act, the following Tribunals, namely:— (a) a Grievance Redressal Forum to be known as the "Health Tribunal" established by the State Government for areas having a population of not more than 20 lac of the State by notification:

4. Composition of the Health Tribunal.—(1) Each Health Tribunal is a quasi – judicial body and shall consist of,—

(a) a person who is, or has been, or is qualified to be a District Judge, who shall be its President;

(b) two other members, one of whom shall be a woman, who shall have the following qualifications, namely:—

(i) be not less than thirty-five years of age

(ii) be persons of ability, integrity and standing, and have adequate knowledge and experience of at least ten years in dealing with problems related health and health care

(c) At least one member among them must possess a qualified medical degree from a recognised university

Provided that a person shall be disqualified for appointment as a member if he possesses any disqualification to be appointed as members of Consumer Redressal Agencies under COPRA, 1986

4. Jurisdiction of the Health Tribunal—(1) Subject to the other provisions of this Act, the Health Tribunal shall have jurisdiction to entertain Grievance in the respective area. A Grievance shall be instituted in a Health Tribunal within the local limits of whose jurisdiction,—

(a) the opposite party or each of the opposite parties, where there are more than one, at the time of the institution of the complaint, actually and voluntarily resides or provides medical services

(b) any of the opposite parties, where there are more than one, at the time of the institution of the grievance, actually and voluntarily resides, or provides medical service

(c) the cause of action, wholly or in part, arises.

5. Appeal.—any person aggrieved by an order made by the Health Tribunal may prefer an appeal against such order to the Health Appellate Tribunal within a period of thirty days from the date of the order, in such form and manner as may be prescribed:

Provided that the Appellate Tribunal may entertain an appeal after the expiry of the said period of thirty days if it is satisfied that there was sufficient cause for not finding it within that period.

6. Composition of the Health Appellate Tribunal—(1) Each Health Appellate Tribunal shall consist of—

(a) a person who is or has been a Judge of a High Court, appointed by the State Government, who shall be its President:

(b) not less than two, and not more than such number of members, as may be prescribed, and one of whom shall be a woman, who shall have the following qualifications, namely:—

(i) be not less than thirty-five years of age;

(ii) be persons of ability, integrity and standing, and proven records in dealing with social issues and have adequate knowledge and experience of at least ten years in dealing with problems related health and health care

(c) A least one among them possess a qualified medical degree from a recognised university.

Provided that a person shall be disqualified for appointment as a member if he possesses any disqualification to be appointed as members of Consumer Redressal Agencies under COPRA, 1986

Provided that not more than fifty per cent of the members shall be from amongst persons having a judicial background.

7. Jurisdiction of Health Appellate Tribunal—(1) Subject to the other provisions of this Act, the Health Appellate Tribunal shall have jurisdiction—:

(a) to entertain appeals against the orders of any Health Tribunal within the State; and

(b) to call for the records and pass appropriate orders in any consumer dispute which is pending before or has been decided by any Health Tribunal within the State, where it appears to the Health Appellate Tribunal that Health Tribunal has exercised a jurisdiction not vested in it by law, or has failed to exercise a jurisdiction so vested or has acted in exercise of its jurisdiction illegally or with material irregularity.

8. Appeal —Any person aggrieved by an order which involves substantial question of law, made by the Health Appellate Tribunal in exercise of its powers may prefer an appeal against such order to the National Health Appellate Tribunal within a period of thirty days from the date of the order in such form and manner as may be prescribed:

Provided that the National Appellate Tribunal may entertain an appeal after the expiry of the said period of thirty days if it is satisfied that there was sufficient cause for not filing it within that period. Whereas appeal to the National Health Tribunal shall be subject to the leave of the Tribunal. After a preliminary hearing the Tribunal may reject to entertain appeal if it finds the matter contains no substantial question of law.

9.Jurisdiction of National Health Appellate Tribunal- Subject to the other provisions of this Act, the National Health Appellate Tribunal shall have jurisdiction— (a) to entertain appeals against the orders of any Health Appellate Tribunal involving substantial question of law and

(b) to call for the records and pass appropriate orders in any consumer dispute which is pending before or has been decided by any Appellate Health Tribunal where it appears to the National Health Appellate Tribunal that Health Appellate Tribunal has exercised a jurisdiction not vested in it by law, or has failed to exercise a jurisdiction so vested or has acted in exercise of its jurisdiction illegally or with material irregularity.

10. Composition of National Health Appellate Tribunal.(1) National Health Appellate Tribunal shall consist of—

(a) a person who is or has been a Judge of the Supreme Court, appointed by the Central Government, who shall be its President and such number of judicial members decided by the Central Government.

Provided that a person shall be disqualified for appointment as a member if he possesses any disqualification to be appointed as members of Consumer Redressal Agencies under COPRA, 1986.

11 Every appointment shall be made by the Central/State Government on the recommendation of a selection committee consisting of the following, namely:—

(i) The Chief Justice of the Supreme Court/State High Court—Chairman.

(ii) Secretary, Law Department of the Union/State—Member.

(iii) Secretary of the Department of Health and Family welfare in the Union/ State—Member.

(IV) Representatives from Health Right Activists

(V) Representatives from Active Consumer Organizations.

12.Appeal.—Any person, aggrieved by an order made by the National Commission in exercise of its powers conferred by sub-clause (i) of clause (a) of Section 21, may prefer an appeal against such order of the Supreme Court within a period of thirty days from the date of the order:

Provided that the Supreme Court may entertain an appeal after the expiry of the said period of thirty days if it is satisfied that there was sufficient cause for not filing it within that period.

13. Tenure, salary and other perks of the members of Tribunal shall be prescribed by the appropriate governments from time to time

14. Procedure before the tribunals, manner of filing grievance, rules regarding expediency finality of orders, administrative control by the Appellate Tribunals, power to remove difficulties and protection for action taken under good faith shall be as prescribed under Consumer Protection Act, 1986.

15 A duty shall be cast on the Health Tribunals for creating awareness regarding the rights of patients within their respective population. For this purpose, the State Government shall sponsor and facilitate by:

i. Conducting seminar, holding lectures to specified group of population and organizing competitions among students

ii.Using electronic and other media

16. Notwithstanding anything contains in any legislation, a registered health care provider shall be liable to pay a particular percentage of his annual income in any case of proven case of deficiency in medical care to the injured party.

Scope for Further Study

This study is focusing on civil liability for deficiency in medical service under Consumer Protection Act; 1986 with an emphasis on surgical treatment. Enumerable further studies can be originated as an offshoot of this analysis. The following are some of them.

- Though the general tendency in India is to consider Medical Negligence as a civil wrong, criminal cases are also filed and doctors are prosecuted in gross medical negligence cases. An analytical study on criminal liability – situations in which it is attracted, legal position, extent- for Medical Negligence will enrich the respective legal spectrum.. This will be particularly informative when a comparative analysis of both these branches of law and their effect on prevention is made in Indian context.
- COPRA is not applicable to services rendered free of charge in Government hospitals, leaving large majority of poor patients availing public health care, outside its purview. The remedy available to them is to approach High

Courts through a writ petition. Therefore constitutional liability for Medical Negligence gathers significance.

- As a part of studying Medical Negligence liability, a separate analysis in done with respect to law relating to medical consent in India. Studies more focused on medical consent of mentally challenged patients, ethics and legal aspects of therapeutic privilege etc. are relevant and requires deeper study.
- Civil liability for deficiency in service during clinical trials is an emerging topic and a subject of serious attention.

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CURRICULAM VITAE

1 K K SUNITHA
Asst.Professor (Business Law)
V.K.K.Menon College, University of Mumbai
Mumbai-42
Email:sunithakk36@gmail.com
Tel: **25457887**(Res) / **9833536130** (M)

RESEARCH EXPERIENCE

- Research Scholar, College of Legal Studies, University of Petroleum and Energy Studies, Dehradun

List of Publications

- K.K.Sunitha & Tabrez Ahmed(2016),The 'Real' Road to Informed Consent:A future perspective for Indian Law on Medical Consent,IUP Law Review ,July 2016 Vol.VI No.3 29-52
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PROFESSIONAL EXPERIENCE:

- Assistant Professor in Sidharth College of Law ,Fort,Mumbai(Jan 2004 to May 2004)
- Assistant Professor, G.J. Advani Law College ,Bandra West,Mumbai (Oct 2004 to Nov 2005)
- Visiting Faculty in TMC Law College, Thane West (Jan 2004 onwards)
- Assistant Professor(Business Law) ,V.K.K.Menon College,Mumbai-42 (June 2006 onwards)

ACADEMIC QUALIFICATIONS:

- **NET**- National Eligibility for Lectureship by UGC (June 2002)
- **LL.M** (Administrative Law)- University of Calicut, Kerala (2002)
- **LL.B** (Taxation Law) -University of Calicut, Kerala (1999)
- **B.Com** (Cost Accounting) -University of Calicut, Kerala (1996)