TOPIC : MEDICAL NEGLIGENCE AND CONSUMER PROTECTION MECHANISM

History :

The concept of Medical Negligence finds its place in the *'Code of Hammurabi'* which was developed by Babylon's Kings some 20 centuries before the Christian era and includes fees for treatment and penalties for improper treatment. The *'Law of Talion'* by Israelites evolved *'an eye for an eye, a tooth for a tooth'.* Ancient Egyptian law provided for the negligent healer's banishment or death. Roman civil law was designed to punish medical wrongdoers so also the Medieval law was equally hard on errant 'barbers and surgeons'.

The word *'mithya'* which means false, illusive, incorrect, erroneous, wrong and improper, has been used to describe the negligent medical treatment. *Charaka Samhita* uses the word in the sense of wrong treatment. *Sushrutha Samhita* uses the word *'mithyopachra'* in the sense of improper conduct. Physicians who act improperly are liable to punishment and quantum of penalty varies according to the status of the victim. The *Manusmriti* advocates payment of fine. In fact, the concept of damages for medical negligence varied on the basis of the severity of injury or loss of life and even in cases of the growth of the disease due to negligence or indifference.

Tort and Civil Negligence :

Historically civilizations considered medical negligence as a crime, which is an offence against the State or the public at

large. As the victims were usually not awarded any damages in criminal proceedings, the subject was increasingly treated as a tort by the judiciary so that victims can be provided with damages. Civil negligence is a form of negligence in which a patient brings an action for damages in a Civil Court against his medical attendant, who owed him a duty of care, if he had suffered injury in consequence of negligence or unskilled treatment.

Briefly stating the above position as it crystallized to the present day scenario, remedy maybe available to redress the grievances both in the Penal provisions as well as in the provisions of the Consumer Protection Act, 1986 (in short "the Act, 1986") and the Rules framed thereunder including the amendments made from time to time. The Act, 1986 have provided for establishment of (i) 'District Forum' by the State Government in each district, (ii) 'State Commission' also by the State Government and (iii) a 'National Consumer Redressal Commission' by the Central Government. Notably, medical profession within the definition of *'services'* was included under *Section 2(1) (o) of the Act, 1986 by the National Commission in 1992* in an appeal from Kerala State Commission. The said inclusion was put to challenge by the Indian Medical Association before the Hon'ble Supreme Court in a Special Leave Petition. In 1995 the Supreme Court decisively included the health profession under the Act with regard to the services rendered by private and government doctors and hospitals in the decision rendered in *"Indian Medical Association –Vs- V P*

Shantha" reported in *(1995) 6 SCC 651*. It however exempted only those hospitals and the medical practitioners of such hospitals, which offer free services to all patients at all times. Similarly, all government hospital except primary health centres where everybody is treated free of cost irrespective of their economic status did not come under the purview of the Act.

The Apex Court authoritatively clarified certain/following facts in the matter –

- *the Consumer Disputes Redressal Agencies are provided with the same powers as are vested in the civil court under the Code of Civil Procedure while trying a suit;*

- *the procedure followed for determination of consumer disputes under the Consumer Protect Act is summery in nature involving trial on the basis of affidavits;*

- *it will be for the parties to place the necessary material and the knowledge and experience, which would enable the Consumer Disputes Redressal Agencies to arrive at their findings on the basis of the material;*

- *obvious faults which do not raise any complicated questions can be speedily disposed of by the*

procedure i.e. being followed by the Consumer Disputes Redressal Agencies;

- *the principle of 'Bolam Test' as laid down by McNair J in Bolam v. Friern Hospital Management Committee, is to be applied to determine the standard of care which is required by medical practitioner in an action for damages for negligence;*

- *in complaints involving complicated issues requiring recording of evidence of experts, the complainant can be asked to approach the civil court for appropriate relief;*

- *service rendered by the doctors and hospitals where charges are required to be paid by persons availing the services but certain categories of persons who cannot afford to pay are rendered service free of charges, which nevertheless fall within the ambit of the expression 'service' as defined in Section 2 (1) (o) of the Act.*

The Principles of 'Bolam Test' :

Based on an English decision of Mc Nair J rendered in "*Bolam V. Friern Hospital Management Committee*" and reported in *(1957) 2 All ER 118* that the present Indian Law has emerged in Civil Negligence by applying the principles of 'Bolam Test' for determining the standard of care which is

required by medical practitioners in an action for damages. It was held :

> *"A doctor will not be guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art and if he has acted in accordance with such practice then merely because there is a body of opinion that takes a contrary view will not make him liable for negligence. (Bolam p. 122 B-C)"*

At this juncture pertinent to mention two decisions rendered by Hon'ble Supreme Court namely, *Dr. Laxman Balakrishna Joshi –Vs- Dr. Trimbak Bapu Godbole & Anr. (reported in AIR 1969 SC 128)* and *A.S. Mittal –Vs- State of U.P. (reported in AIR 1989 SC 1570)* wherein it was held that when a doctor is consulted by a patient, the doctor owes to his patient certain duties which are *(a) a duty of care in deciding whether to undertake the case; (b) a duty of care in deciding which treatment to give; and (c) a duty of care in administration of that treatment*. A breach of any of the above duties may give a cause of action for negligence and recover damages.

That apart, there must be established casual (cause and effect) connection between breach of duty and injury suffered by the Complainant and the burden of proof lies on the

Complainant. Further injury suffered must sufficiently proximate to Medical practitioner's breach of duty as held in a case reported in *(2009) 7 SCC 330 (Post-graduate Institute of Medical Education and Research –Vs- Jaspal Singh.*

In *Achutrao Haribhan Khodwa [1996 (2) SCC 634]* it was inter alia, held by the Hon'ble Supreme Court that merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession. In the realm of diagnosis and treatment there is scope for genuine difference of opinion amongst doctors.

There is also a view by the High Court of Australia in *Rogers' Case* (reported in 1993) that the question is not whether the doctor's conduct accords with the practice of a medical profession or some part of it, but whether it conforms to the standard of reasonable case demanded by the law and that is the question for the court to decide. The duty of deciding it cannot be delegated to any profession or group in the community.

Pertinently noteworthy that the standard of proof as also culpability requirements under Section 304-A of the Penal Code in comparison stand on an altogether different footing to that of the law of tort or the Consumer Protection Act. In fact, an act which may constitute negligence or even rashness under torts may not amount to the same under Section 304-A. For fixing criminal liability on a doctor or surgeon, the standard of

negligence required to be proved should be so high as can be described as 'gross negligence' or 'recklessness'. This comparison is based on the views of the Hon'ble Supreme Court rendered in the case of *Malay Kr. Ganguly reported in (2009) 9 SCC 221 (Para 133)*.

(A) <u>Individual Liability of Doctors :</u>

There cannot be, however, any doubt or dispute that for establishing medical negligence or deficiency in service, the courts would determine the following :

(i) *No guarantees given by any doctor or surgeon that the patient would be cured.*

(ii) *The doctor, however, must undertake a fair, reasonable and competent decree of skill, which may not be the highest skill.*

(iii) *Adoption of one of the modes of treatment, if there are many, and treating the patient with due care and caution would not constitute any negligence.*

(iv) *Failure to act in accordance with the standard, reasonable, competent medical means at the time would not constitute a negligence. However, a medical practitioner must exercise reasonable degree of care and skill and knowledge which he possesses.*

Failure to use due skill in diagnosis with the result that wrong treatment is given would be negligence.

(v) *In a complicated case, the court would be slow in contributing negligence on the part of the doctor, if he is performing his duties to the best of his ability.*

Bearing in mind the aforesaid principles, the individual liability of the doctor and hospital must be judged.

(B) <u>Doctrine of Res ipsa loquitur :</u>

In cases of negligence where the Claimant cannot make out a breach of the Respondent's duty of care, the doctrine *(the thing speaks for itself)* may provide the missing element by conclusion from the nature of injury like bruises, burns and fractures, which have no relation whatsoever with the condition, for which he was being treated. The applicability of the doctrine is based on :

(a) *the nature of injury suggest by common knowledge or expert evidence that without negligence it does not occur;*

(b) *the Claimant (patient) must not continue to his own injury;*

(c) *the Respondent (doctor) must be in exclusive control of the instrumentalities.*

However, exceptions though few in number as quoted in *Black's Law Dictionary* that the doctrine cannot be applied if the case of the harm is known.

(C) Discharge of burden of proof :

Once a claim petition is filed and the Claimant has successfully discharged the initial burden that the hospital was negligent, as a result of such negligence the patient died, then in that case the burden lies on the hospital and the concerned doctor who treated the patient that there was no negligence involved in the treatment. The burden is therefore greater on the institution/hospital to overcome the weak links that has caused the damage. The principle was laid down by the Hon'ble Supreme Court in the case of *Smt. Savita Garg -Vs- The Director, National Heart Institute, reported in (2004) 8 SCC 56.*

(D) 'Calculated risk' doctrine :

Applicable when the injury complained is of a type that may occur even though reasonable care has been taken. This doctrine is an important defence to any doctor sued for professional negligence or medical negligence, who can produce evidence or statistics to show that the accepted method of treatment he employed, had unavoidable risks. The above view was taken by the National Commission in a case reported in *IV (2004) CPJ 745 (NC) [Para 10].*

(E) <u>Suppression of Medical history amounts to contributory negligence :</u>

Sometimes the unexpected results may be due to non disclosure about previous medical history including ailment/treatment undergone by the patient. Therefore the Court recognizes, in addition, that patients are responsible for exercising ordinary care in revealing information to their physicians and those physicians have the primary responsibility for eliciting an accurate history from their patients due to their greater wealth of medical knowledge.

In *Jacob Mathews [2005 (6) SCC 1]* the Apex Court in conclusion inter-alia, observed that a case of occupational negligence is different from one of profession negligence. A simple lack of care, an error of judgment or accident, is not proof of negligence on the part of a medical profession. In case of an error of judgment in choosing one reasonable course of treatment in preference to another cannot be an act of negligence unless the conduct of the medical practitioner fell below that of the standards of a reasonably competent practitioner in the field.

(F) <u>Line of treatment : the options available and preference of the treating doctor cannot make him attributable to negligence :</u>

The National Commission in *Ram Chandra Rai's* Case reported in *IV (2014) CPJ 549 (NC) [Para 8)* placed reliance in the decision of *A.H. Khodwa* reported in *(1996) 2 SCC 634* wherein the Hon'ble Supreme Court observed that, in the very

nature of medical profession, skill differs from doctor to doctor and more than one alternative course of treatment are available, all admissible.

(G) Autopsy or Post-Mortem :

Necessity for an Autopsy or Post-Mortem in a case of sudden, unexplained, unexpected death, was considered by the National Commission in the case of *Renu Jain and Others – Vs- Escorts Heart Institute & Research Centre reported in II (1992) CPJ 391* and held it in affirmative.

(H) Consent :

The doctor has to seek and secure the consent of the patient before commencing a treatment (and includes surgery also). It should be valid and real, i.e. capacity and competence of the patient to consent voluntarily based on adequate information concerning the nature of treatment procedure, as held by the Hon'ble Supreme Court in *Samira Kohli's Case* reported in *(2008) 2 SCC 1 (Paragraph 49)*. The view taken by Supreme Court in *Martin F. D'Souza reported in (2009) 3 SCC 1 (Para 38)* is that the higher the acuteness in an emergency and the higher the complication, the more are the chances of error of judgment. The doctor is often called upon to adopt a produce which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Which course is more appropriate to follow, should be left open to the doctor depending on the

facts and circumstances of a given case. The doctor adopting the procedure involving higher element of risk, cannot be penalized if it ends in failure. Ideally, written consent be obtained from the patient or his guardian in case of emergency before adopting a given procedure.

Conclusion :

The Consumer Protection Act, 1986 is a beneficial legislation aimed at providing better protection of the genuine interests of the consumers and even in matters pertaining to medical negligence. In doing so, the health sector, which is a delegated sovereign function of the State is adequately regulated by the Consumer Protection Mechanism.

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