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DISSERTATION

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ON THE TOPIC

"Critical Analysis of Legal Regimes for Medical Negligence in India- Need for a Comprehensive Legal Framework"

Under the Guidance and Supervision of

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CERTIFICATE

This is to certify that Ms. Arya Raj (Reg No. LM0320003) has submitted her dissertation titled **"Critical Analysis of Legal Regimes for Medical Negligence in India- Need for a Comprehensive Legal Framework"** under my guidance and supervision. Her work was satisfactory and done honestly upholding the integrity of research. I hereby approve her submission.

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Place: Ernakulam

DECLARATION

I declare that this Dissertation titled "***Critical Analysis of Legal Regimes for Medical Negligence in India- Need for a Comprehensive Legal Framework***" is researched and submitted by me to the National University of Advanced Legal Studies, Kochi in partial fulfilment of the requirement for the award of Degree of Master of Laws in Public Health Law, under the guidance and supervision of Dr. Ambily Perayil, and is an original, bona fide and legitimate work. It has been pursued for an academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this University or any other University.

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ABBREVIATIONS

ABBREVIATIONS	FULL FORM
• ART.	ARTICLE
• IPC	INDIAN PENAL CODE
• U.N	UNITED NATION
• SCC	SUPREME COURT CASES
• AIR	ALL INDIA REPORTER
• CrLJ	CRIMINAL LAW JOURNAL
• Ibid	IBIDEM (SAME)
• Supra	PREVIOUSLY CITED
• V.	VERSUS
• S. OR SEC.	SECTION
• P.	PAGE
• Pvt.	PRIVATE
• Ltd.	LIMITED
• Co.	CORPORATION
• Vol.	VOLUME
• Iss.	ISSUE
• CRPC	CRIMINAL PROCEDURE CODE, 1973
• IMA	INDIAN MEDICAL ASSOCIATION
• IMC	INDIAN MEDICAL COUNCIL
• NMC	NATIONAL MEDICAL COMMISSION

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CHAPTER 1: INTRODUCTION

"*In my opinion, our health care system has failed when a doctor fails to treat an illness that is treatable*."

- Kevin Alan Lee

'Medical Negligence' is a predominant factor as far as a patient is concerned. Bharath, a nation that limned and worshiped the medical practitioners as a 'God' or as a divinity has now entered to an incertitude. The main reason is the hike in the number of medical negligence, instances that transpired in the recent times. Over the past few decades, medical negligence has become one of the grave concerns in the country. It has been made evident that the medical profession one of the noblest professions is no more immune to negligence, which frequently result in fatalities or complete or partial impairment of limbs or which further culminates into another misery of the patients. There are several instances of in-competent or under educated doctors on their volition have taken a toll on the innocent patient. And in any case, such magnitude of negligence or deliberate conduct of the medical professionals or plaintiffs to appropriate their entitlements. Indeed, medical negligence is a nodus which is of serious human right concern that directly affects 'right to life' and 'right to healthcare'. The rising number of incidents of medical negligence in India mostly goes in vain without any legal action. Which in turn leads to a complete erosion of public trust on the medical service providers. Notwithstanding, that the legal remedies or recourse available under the existing laws are limited or difficult to access, such efforts provide a clear picture about the shortcoming of the existing law and the underlying difficulties in the judicial system. The main purpose of this study is to appraise the medical negligence law in India, so as to ascertain the legal status of medical negligence in the country.

In order to penetrate the concept of professional negligence from there to medical negligence it is important to understand the meaning of the term 'profession', especially in the current scenario of medico-legal conflict. The Oxford Advanced Learner's Dictionary has defined

'Profession' as a paid occupation especially one that requires advanced education and training knowledge and education and the nature of work carried out by the professionals are extremely specialized thus it requires more mental than physical work. The very same ground differs 'profession' from that of an 'occupation'.

In the landmark judgment of **Indian Medical Association V. V.P. Shantha and others** the Supreme Court of India categorically held that

''*Profession in the present use of language involves the idea of an occupation requiring either purely intellectual skill, or of manual skill controlled, as in painting and sculpture, or surgery, by the intellectual skill of the operator, as distinguish from an occupation which is subsequently the production or sale or arrangement for the production or sale of commodities. The line of occupation may vary from time to time*."

One of the distinctive aspects of a professional work is that it is ruled by some ethical or moral principles, which definitely demands a higher level of honesty and integrity. Undoubtedly, these principles are beyond the legal requisitions and give professional the very respect and put them in a higher pedestal in the community. With respect to the medical profession in spite of all the aspersions even during this present era of commercialization, this profession has been able to sustain its esteem position to a great extent because a large part of the Indian society still believes that monetary benefits are not the predominant consideration for a medical professional.

The next important definition needs to ascertain is that of the term **'Medical Practitioner'**. In the **Poonam Verma Case**,[1] the Supreme Court of India defined "*Medical practitioner or practitioner means a person who is engaged in the practice of modern scientific medicine in any of its branches including surgery and obstetrics, but not including veterinary medicine or surgery or the Ayurvedic, unani, homoeopathic or biochemic system of medicine*"

Definition of Negligence

In law 'Negligence' is a kind of Tort wrong or Civil wrong at the same time it is also a wrong under criminal and consumer law. Which implies that an act of conduct is culpable because it falls short of the legal standard required of a reasonable person in protecting individuals against

[1] *Poonam Verma* v *Ashwin Patel* (1996) 4 SCC 332; AIR 1996 SC 2111 at para 41.

the foreseeable risky or deleterious acts. Any negligent behaviour towards another party entitles them a right to be compensated for any harm of their mental and physical health, wealth, property or relationships.

It is known fact that it is very difficult to define negligence; Howbeit, the very concept has been accepted and acknowledged in jurisprudence. In **Jacob Mathew V. State of Punjab and Anr**[2]. The Supreme Court of India defined the term negligence as 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.

1. A legal duty to exercise due care on the part of the party complained of towards the party complaining the former's conduct within the scope of duty.
2. Breach of the said duty;
3. Consequential damage.

The ever-classic definition of negligence was given by B. Alderson. J in the year 1856, in his notable pronouncement in **Blyth V. Birmingham Waterworks Company** he states that '*The omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do. The defendants might have been liable for negligence, if unintentionally, they omitted to do that which a reasonable person would have done, or did that which a person taking reasonable precautions would not have done.*'

Consequently, negligence in law is essentially an accidental penetrate of legitimate obligation that generally makes an enquiry someone else. The law thinks about those harmful demonstrations to be guilty, all in all which a sensibly judicious man would predict as being fit for gainful of injury and which he would cautiously go without doing. Altogether, there are three implications of medical negligence, i.e.

i. A state of mind which is opposite to the intention
ii. Careless Conduct

[2] (2005) 6 SCC 1.

iii. The breach of duty to take care imposed by common or statute law

Negligence as a state of mind

Negligence and wrongful intent are two alternative forms of *mens rea.* Out of these two alternative forms one form is essentially required by law as an essential condition for establishing liability of wrongdoer. The wilful wrongdoer or intentional wrongdoer is one who desires to do harm. The negligent wrongdoer is one who does not sufficiently desire to avoid doing it.[3] Thus negligence as a 'state of mind' does not mean an act or a demonstration to deliver them. Yet, it implies lack of concern or heedlessness in guarding in case of such act or omissions occurs.

Negligence as a Careless Conduct

Careless man is one, who does not care or who is not sufficiently anxious that his activities are going to cause loss to others. It does not mean breach of a duty to take care, but simply means careless conduct on the part of the wrongdoer. Negligence with careless conduct is opposite of diligence.

Negligence as the Breach of Duty to take care

Negligence as the breach of duty to take care is simply a neglect of some care which we are bound by law to exercise towards somebody. Under the law of negligence, professionals such as Lawyers, Doctors, architects and others are the persons possessing some special skill. Any task which is required to be performed by these professionals wants a special skill. For a medical accident or failure, the responsibility may lie with medical practitioner, and equally it may not. So, such negligence necessarily be treated with some difference.[4]

Generally, 'Medical Negligence' means failure to act in accordance with the standards of a reasonably competent medical man at that time. It is the breach of a duty owned by doctor to his patient to exercise reasonable care and skill, which results in some physical, mental or financial disability.[5]

'Medical Negligence' is defined as lack of reasonable care and skill or wilful negligence

[3] John Salmond, *Charlesworth on negligence,* 21 (6th Edn.)
[4] *Jacob Mathew* v. *State of Punjab and Another* (2005) 6 SCC 1.
[5] H.M.V. Cox, *Medical Jurisprudence and Toxicology,* 77 (6th Edn., 1990)

on the part of a doctor in respect of acceptance of a patient, history taking, examination, diagnosis, investigation, treatment-medical or surgical, etc., resulting any injury or damage to the patient. Damage in this means physical, mental or financial injury to the patient.[6]

The professional is judged by these two standards. So, the professional can be held liable for negligence when he was not possessed of requisite skill which he professes to held and when he does not exercise it with reasonable care and caution.[7]

Essential Constituents of Negligence:

The essential constituents of negligence have been defined by the Supreme Court in the *Poonam Verma* case[8] as:

a. A legal duty to exercise due care,

b. Breach of duty, and

c. Consequential damages.

All these constituents of negligence must be proved by the plaintiff to the satisfaction of the court and only then can the defendant be held liable for negligence. [9]The Supreme Court held that Cause of action for negligence arises only when damage occurs; for, damage is a necessary ingredient of this tort. If the plaintiff fails to prove that any loss or injury was caused to the patient, in spite of proving negligence by the doctor, he will not be entitled to claim any compensation.[10]

In a deed of negligence, the plaintiff has to prove the following essentials: -

- The defendant owed duty of care to the plaintiff;

- The defendant made the breach of that duty;

[6] S. K. Palo, *Consumer Rights relating to Medical Negligence*, 2006, JMC at page xiii.
[7] Martin. D'Souza v. *Mohd. Ishfaq*, (2009) 3 SCC 6.
[8] (1996) 4 SCC 332.
[9] *Jacob Mathew* v. *State of Punjab and Another* (2005) 6 SCC 1
[10] *Sidhraj Dhadda* v. *State of Rajasthan* AIR 1994 Raj. 68 and 1993 (1) Raj. L.W. 532

- The defendant suffered damage as consequence thereof.

Actionable Medical Negligence

'Actionable negligence' is that which imports or shift the liability of the doer. In view of establishing the liability of clinical negligence, it should be shown that:

I. The doctor has an 'obligation to take care' towards the patient,

ii. The doctor failed to perform or in a breach of that obligation; and

iii. The patient has suffered damages as a result of the breach of that duty[11]

All these three conditions should be present concurrently otherwise no charge of clinical or medical negligence can be claimed.

Duty of Care to the 'Plaintiff'

It is silly to expect any individual to take responsibility for each of his imprudent act or in any event, for each such reckless act that causes harm. He may possibly be at risk for carelessness on the off chance that he is under a legitimate obligation to fare thee well. The lawful obligation is not quite the same as the ethical, strict, or social obligation, and accordingly, the offended party (buyer) needs to build up that the miscreant owed to him a particular legitimate obligation to deal with which he has made a breach. An individual is simply needed to fulfil the guideline of care where he has a commitment or an obligation to be cautious. Thus, it could be said that the "obligation/duty" is "the relation between individuals who forces upon one a legitimate commitment for the advantage of other". In the other words the obligation is "a commitment, perceived by law, to maintain a strategic distance from unreasonable risk of danger to other people." In this manner the presence of duty towards the offended party becomes significant factor for obsession of the obligation of the tortfeasor

Whether the defendant owes a duty to the plaintiff or not depends on reasonable foreseeability to the plaintiff. If at the time of the act or omission, the defendant could reasonably foresee

[11] Ratan Lal Dhiraj Lal, *the Law of Torts*, 441 (2nd Edn. 2005).

injury to the plaintiff he owes a duty to prevent that injury and failure to do that makes him liable. Duty to take care is the duty to avoid doing or omitting to do anything, the doing or omitting to do which may have as its reasonable and probable consequence injury to others, and the duty is owed to those to whom injury may reasonably and probably be anticipated if the duty is not observed.[12]

"The standard of foresight of the reasonable man is, in one sense, an impersonal test. It eliminates the personal equation and is independent of the idiosyncrasies of the particular person whose conduct is in question. Some persons are by nature unduly timorous andimagine every path beset with lions. Others, of more robust temperament, fail to foresee or nonchalantly disregard even the most obvious dangers. The reasonable man is presumed to befree both from apprehension and from over confidence, but there is a sense in which the standard of care of the reasonable man involves in its application a subjective element. It is still left to the judge to decide what, in the circumstances of the particular case, the reasonable man would have had in contemplation and what accordingly, the party sought to be made liable ought to have foreseen. Here, there is room of diversity of views… What to one judge may seem far-fetched to another both natural and probable.

In S. Dhanaveni v. State of Tamil Nadu[13], the deceased slipped into a pit filled with rainwater in the night. He caught hold of nearby electric pole to avert a fall. Due to leakage of electricity in the pole, he was electrocuted. The respondent, who maintained the electric pole was considered negligent and was held liable for the death of the deceased.

In case of Orissa Road Transport Co. Ltd. V. Umakant Singh[14], the bus driver was held liable for the death of two passengers as he tried to cross the level crossing but could not do so due to mechanical defect in the truck. There was enough time to cross the level crossing and he was aware of the mechanical defect. Thus, he was held negligent.

[12] Bourhill v. Young, (1943) A.C 92
[13] A.I.R. 1997 Mad.257
[14] 1987 ACJ 133

The duty to Exercise Skill and Care:

'The duty to exercise skill and care' is the foremost essential condition for establishing the liability for medical negligence. Basically, the 'duty' is an obligation to advance proper care to avoid injury in every situation of the case. Duty to take care is constraint or control on the defendant's freedom which force him to behave in a reasonable manner. In legal context 'medical negligence' means nothing but a substandard care.

The duty to exercise skill and care only arises when a doctor-patient relationship is established. This relationship will take shape by any formed acceptance of a patient by a doctor, or by the payment of any fee. In a situation of an emergency this doctor-patient relationship is formed as soon as the doctor reach out to a patient with the object of treating him. Any kind of breach of this duty is a valid ground for a negligent action.

The concept of 'reasonable foresight' is used to determine the standard required in a Particular case. Reasonable foresight means the foresight of a 'reasonable prudent man'. A reasonable man will avoid producing probable undesirable consequences. That is the normal standard of careful conduct. If the conduct in question falls short of that standard, it is negligent one.[15] In simple terms under a medical negligence case the 'reasonable foresight' is that of a doctor who holds a reasonable degree of proficiency and who equally apply it with a reasonable degree of diligence. Thus, as long as a doctor acts in a manner which is acceptable to the medical profession, then he was attended on the patient with due care, skill and diligence.[16]

The basic principle relating the law of medical negligence is Bolam Rule,[17] i.e., the test is the standard of the ordinary skilled man exercised and professing to have that special skill. A man need not to possess the highest expert skill, it is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. In the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical man at the time. There may be one or more perfectly standards, and if he conforms to one of these proper standards, then he is not negligent."

[15] M. N. Shukla, *The Law of Torts*, 2016 (13th Edn. 1990)
[16] *Achutraq H. Khodwa* v. *State of Maharastra* AIR 1996 SC 2383 at para 15.
[17] *Bolam* v *Friern Hospital Management Committee* [1957] 2 AIIER 118; The Bolam rule recognized and upheld in *Jacob Mathew* v. *state of Punjab and Another* (2005) 6 SCC 1.

Breach of that Duty to Take Care:

The second essential required to be fulfilled for establishing the liability for medical negligence is that there is a breach of the duty to take care on the part of the defendant towards the plaintiff. The breach of duty may be occasioned either by not doing something which a reasonable man would be under similar set of circumstances, or, by doing some act which a reasonable prudent man would not do.[18]

Consequential Damages

In an act of negligence, the aggrieved party substantiating that the defendant was negligent is not enough but must prove that there was actual damage and also this damage probably came about to the respondent or defendant in result of the negligent act, which was the direct and proximate cause of damage. Damages are granted to remunerate the offended party for the harm caused to him also to put him in the similar position in which he would have been if the injury was definitely not. In actions of tort, compensation is the principle of Redressal and the measure of damages is the exact amount of the injury which the plaintiff has suffered in his person, earnings, life expectancy, etc.[19]

Objective of The Study:

The objectives of the research are as follows

- To understand ‘what constitutes’ and ‘what amounts’ to Medical Negligence.
- To dissect the current Legal frameworks which deal with matters about Medical Negligence.
- To Examine the Judicial Approach in India concerning medical Negligence.
- To examine the concept of 'burden of proof' and 'Standard of Care.'
- To Evaluate the need for comprehensive legislation or enactments to grapple with Medical Negligence.

[18] *Poonam Verma* v *Ashwin Patel* (1996) 4 SCC 332; AIR 1996 SC 2111 at para 16
[19] W. Wyatt-Paine, *The Law of Torts*, 140 (7th Edn., 1921)

Research Questions:

- What are the current legislation and enactments deals with Medical Negligence?
- Whether the existing laws on these sectors are sufficient to respect and protect the parties' interests?
- How crystalized are the Judicial perspectives on Medical Negligence?

Hypothesis:

- The current legislations are inadequate in confronting the causes that lead to Medical Negligence.
- Legal Position with respect to the calculation or quantum of compensation in Medical Negligence.

Research Methodology:

In pursuing the research on this chosen topic, the researcher intent to employ the concept of Doctrinal research with data analysis. The thesis will be compiled with the help of a literary survey. The major methodology of the research is analytical method along with the support of the empirical and descriptive method.

Chapterization:

- Introduction
- Historical Evolution of Medical System and Medical Negligence
- Legislations or Legal provisions, Enactments, Regarding Medical Negligence in India
- Comparison of the Indian Medical Negligence Laws with the Laws of England and America
- Judicial Redressing Towards Medical Negligence
- Conclusion and suggestions

CHAPTER-2: THE STORY OF ART OF HEALING: HISTORICAL DEVELOPMENTS AND EVELOUTION OF MEDICAL SYSTEM AND MEDICAL NEGLIGENCE

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I. Introduction

The birth of "socialization of medicine" or "art of healing" is so conjugated with a man's inherent emotions of empathy and kindness. The traces of innovations that are old thousands of years are the very proof of the strong desire of palaeolithic man to advance cure and relief to the sufferings and illness of his fellow beings. However, for the primordial or prehistoric societies, due to their limited information and knowledge, an illness, or an epidemic, or any other calamities were discerned as either the anger of God or possession of one's body by negative energy or it is regarded as an astronomical or astrological attribute. As they believed the sickness and diseases are the outcomes of the anger of God, their style of curing and healing majorly consists of performing yajnas, chanting mantras, scarification, pujas, and other rituals or exorcisms to evict demons or evil spirits from the human body. Though there are few records available, but there exist other practices such as herbalism[20] in which plants were used for medicinal purposes or as healing agents, later the same was even developed to medicinal knowledge base and imparted to generations. Similarly, clays and soils were also being considered as healing agents; further, there are traces of sharp stones and flint-hard instruments like drills and bowstrings, which facilitated the primitive man to carry out surgeries and amputations. Thus, in short, it is so apparent that the practice of medicine in the prehistoric era, i.e., 5000BC, was a mixture of religion, superstitious beliefs, black and white magic, and a little of naturopathy or self-healing. The history of medicine from the prehistoric phase to the twentieth century's strategized preventive medicine and modern surgery corroborates the transformation of societies in their perception and approach to an illness and disease from the primitive period to the present.

The practice of surgeries and amputations hugely paved the way for the concept of medical Negligence. This concept of medical Negligence was pinned down four thousand years ago; the limited resources states that the Babylonian King Hammurabi propagated a law to deals with the medical Negligence act committed by the doctors. This law mandates that during the conduct of surgery, if a patient loses his eyes, then the practitioner or the doctor shall himself amputates his hands.

[20] The study or practice of the plants which has medicinal or therapeutic essence, it is regarded as a kind of alternative medicine.

It was in 1374, a medical Negligence suit under English law was filed, which was considered to be the first-ever recorded medical Negligence suit under English law. In the said case, the plaintiff suffered an injury in his hands as a consequence of alleged wrong treatment or Negligence on the part of the defendant surgeon, Mr. J. Mort. Subsequently, the plaintiff brought a suit against the surgeon for his alleged act of Negligence; however, the court observed that the surgeon performed his actions with due diligence, that it is not right to hold him culpable. Hence, the defendant was not held liable for the alleged wrong committed by him[21]

Cross V. Gutheri[22]is the first medical negligence suit filed in United States of America in the year 1794. This is a case of a patient who suffered complications and died just three hours after the postoperative mastectomy[23]. The suit was proffered by the patient's husband against Dr. Cross, a Connecticut physician who headed the surgery, on the sole ground that the physician breached his promise or violated the undertaking that of conducting the operation skilfully and with due diligence. The deciding officers found the physician accountable for the said grave breach and awarded damages or compensation on the ground of loss of companionship[24].

The concept of medical Negligence presently followed in India is not originally from India; it is a styled and seasoned version of English Law. Under English law, medical Negligence is treated as a separate tort, where in Scotland, it is termed as a delict. In the United States of America before the early 1800s, the concept of medical Negligence was quite unknown and unheard of; however, during the period of 1835-1865, the country witnessed a hike in the number of medical negligence lawsuits. Most of these lawsuits bore cases of fractures and dislocations, which resulted in unpleasant outcomes such as disproportion or malfunctioning of limbs and muscles.

It is an ancient practice to take certain vows or pledges before entering into this noble profession of medicine. The Hippocratic Oath, which has scripted in ancient Greece in

[21] Umeshwari Dkhar, *Status of Victims of Medical Negligence; A Critical Analysis*, Volume 4 (3), IJIRAS, ISSN: 2394-4404, February (2017)
[22] Cross v. Guthrie, 2 Root 90 (Conn.
1794)
[23] Mastectomy- surgical removal of all or part of the breast and sometimes associated lymph nodes and muscles
[24] Robert J. Flemma M.D, *Medical Malpractice: A dilemma in the search for Justice*, Volume 68 (2), Marquette Law Review, 1985

the 5th century BCE regarded as the fundamental oath document for the physicians across the globe to swear upon before entering into their profession; it later became the principal inspiration for many other oaths. Charaka Samhita, a manuscript of primitive India, is considered to be one of the oldest oaths for the medical profession. This oath encourages medical professionals to sacrifice personal benefits and to dedicate themselves to serve mankind. Howbeit, with the pace of time, these codes seem to have dodged their importance, and it became a mere customary document which used by the medical student to take the Hippocratic Oath on their graduation day; otherwise, it is so rarely remembered or implemented in practice.

II. Evolution of Medical System Across the World

1. **Medicine under Greek System**[25]: Primitive Greek medicine was a fusion of theories and practices; with the exploration and implementation of various new ideologies and trials, these theories and practices were put to dynamic expansion on a constant basis. Most of the elements or components of ancient Greek medicine have an immixture characteristic that entwined the spiritual aspects with the physical. Particularly, the theories and ideologies from which primitive Greek medicine originated embody the geographic or geological locations, social class, and ethnicity, gender and age, food culture, struggles and traumas, humor[26], beliefs, and mindset, etc. Like, any other ancient culture of medicine, ancient Greeks also accounted that sickness or epidemics are "God's retribution" against the sin committed by mankind, whereas healing or curing are considered to be vindication or "mercy of God." As mentioned before medical system in ancient Greek always subjected to constant experiments and trials in which many theories were turned out to be fallacious as they caused unpleasant outcomes on the symptoms and results, and some became bygone. As a result of these trials and the emergence of new ideologies, ancient Greek medicine also started outgrowing from its classic system, which was purely based on spiritual beliefs, to more physical and realistic, i.e., cause and effect based.

[25] Fieliding H. Garrison, *History of Medicine with medical Chronology, Suggestions for study and Bibliographic Data*, Fourth Edition.

[26] in medieval physiology: a fluid or juice of an animal or plant
specifically: one of the four kinds of fluids entering into the constitution of the body and determining by their relative proportions a person's health and temperament

2. **Indian Scenario**: The Atharvaveda, an ancient scripture of Hinduism dating from the beginning of the Iron Age, is one of the first Indian scripts to discuss medicines and the art of healing. It also accommodates the prescription of herbal plants for various sicknesses; the practice of using herbs or plants that contains medicinal properties later becomes the fundamental part of Ayurveda.

   Ayurveda is regarded as the dominant medical system in ancient India; it is considered to be the oldest and traditional Indian medical system. The ancient or classic version of Ayurveda was a blend of traditional herbal practices along with conceptualization of theories or establishing theories. Which purports that Ayurveda has a theoretical explanation for every healing technique or method they practice to treat a particular illness, the theoretical conceptualization of new nosologies[27] and many such new therapies dated 600 BCE are the best examples of the same.

   During the medieval period, another branch of medicine called Unani gained much prominence. It transpired as an alternative system of medicine in India. Unani, which was brought to India by the Islamic and Greek rulers, could fetch deep roots and bagged royal patronage during the Indian sultanate and Mughal periods. The core system of Unani medicine is very similar to that of Ayurveda since both the systems the study and practice are based on the five fundamental elements (Fire, Water, Earth, and Air) present in the human body. Unani system of medicine posits that the presence of said five elements is in the form of various fluids in the human body; any variations or disproportion in these liquids will affect the orchestration of the entire human body and thus will cause ailments.

3. The Sanskrit-oriented medical doctrines and knowledge were predominant and received much respect and acknowledgment even during the 18th century A.D. During the 15th and 17th centuries, the Islam rulers inscribed several commentaries on ancient medical scriptures, and it was in this duration they constructed huge hospitals in Delhi and Hyderabad.

[27] The area of medicine that studies the classification of diseases.

4. The phase between 800 BC to 600 AD is regarded as the Golden Period (citation) of Indian Medicine. This is the period in which innumerable eminent scholars from various countries such as Tibet, Afghanistan, China, the Romans, the Greeks, Egyptians, and Persians, arrived in Indian Ayurvedic Patashalas[28] to research, learn, and equip themselves about this unique system of medicine. The teaching and practice of traditional medicines that prevailed in India were followed in accordance with the Ayurvedic or ancient Vedic Hindu principles, wherein Unani or the Arabic-based medicine is in line with the Egyptian and Greecian schools of medicines.

5. Charaka and Susruta were the prime exponents of Ayurveda; their unparalleled profundity was in comparison with pioneers of foreign medicines such as Hippocrates and other Greek physicians. The knowledge and prudence of these great Indian teachers were acknowledged and accepted across the globe, not only in the sphere of basic medical sciences, surgeries, and therapeutics but also in crafting the ethical code for the practice of medicine and nursing. However, at the beginning of the 19th century, under British rule, the British Government of India resisted and denied entrusting the health care of the British community in the fold of Ayurveda and Unani. Thus, they brought medical practitioners from Europe to India to facilitate medical care to their own men. Eventually, the British physicians or Surgeons who came from Europe trained and equipped few Indians with the basic principles of diagnosis and treatment of ailments and appointed these trained Indians as “Native Doctors" to assist them in health care as compounders or apprentices.

6. The British surgeons were much impressed by the dedicated services showcased by these Native doctors; thenceforth, on 19th May 1822, the Medical Board of the British Surgeons wrote to the then Secretary to the Government of India for manifesting a more systematized medical education for the Native doctors. After the receipt of official approval on 24th May 1882, the first Medical School in British India was instituted under the Government Order dated 21st June 1822. The Medical School was inaugurated and started functioning on October 1824 inside the campus of Calcutta Sanskrit College; Dr. James Jamieson was appointed as the first superintendent.

[28] A traditional Hindu school which prevailed in primitive India, where children are taught in Sanskrit by Brahmins or other Experts.

7. Medicine under Islamic System: One of the significant parts of the Islamic civilization was the progressions it brought to the branch of medical sciences, and the core reason was the exceptional contributions made by its physicians in the medical fields, including pharmacy and pharmaceutical sciences, pharmacology, physiology, surgery, anatomy, ophthalmology. The medicine under the Arab system was influenced and inspired by Byzantine[29]Greek, ancient Indian, and Roman medical practices. Hippocrates and Galen[30]were regarded as the predominant exponents or authorities; more than a hundred works of Galen were translated into Arabic by Nestorian Christian Hunaynibn Ishaq. Inevitably, Galen's exhortation on a rational and systematic approach to medicine set the framework for Islamic medicine, which later gained much popularity across the Arab dynasty.

8. Medical situations in Britain: In Britain, towards the mid of 15th century, as a milestone, they could establish three small hospitals. Till the mid-16th century whole of Britain, i.e., a major population belong to city, town or even countryside for medical care depended on a local novice with zero professional guidance but who perhaps pacified the ailments with some traditional herbs or with a bit of magic. However, later in 1696, the London Dispensary, the first-ever clinic under the British dynasty, started functioning with the focus to advance medicine and basic healthcare to the unprivileged population. Though the idea took time to expand, by the early 17th century, more dispensaries were on a roll. Later on, small hospitals were opened in few colonies like one in Philadelphia in 1752, Massachusetts General Hospital in 1811 in Boston, at New York in 1771.

III. Chronicle of Indian Medical Treatment:

The Portuguese were the first to bring Western medicine to India[31]. During the British colonial period, the medical officers of the East India Company also have a good

[29] The Byzantine Empire referred to as the Eastern Roman Empire or Byzantium, a royal community which believed to be the heirs of the Roman Empire in its eastern provinces during the Middle Ages
[30] Galen, was a Greek physician, philosopher, and a writer, one of the trailblazer and pioneer in medical theory and its practice in Europe, from the Middle Ages to the mid of 17th century
[31] Upinder Singh, Nayanjot Lahiri, *Ancient India: New Researc*h, Oxford University Press, India 2010

portion in sowing the seeds of Western medicine in India. The initial intention of the East India Company to establish medical departments with surgeons in British India was to advance health care to the British Army and employees of the East India Company.[32]. Gradually, in 1775 hospital boards consisting of the Surgeon General and Physician General were set up. Medical departments of East India Company were instituted in Bengal, Madras, and Bombay presidencies, and the constitution of health boards in each presidency was essentially executed by the staff of the Commander-in-Chief of the British Indian Army of particular presidencies. Further, the supervision and administration of the medical departments were under the Military personnel and British civilians.

After the disintegration of the East India Company as consequential to the mutiny of 1857, British rule came on its wheel in India. Under British India, Indian Medical Service, an exclusive medical-oriented, organized body, was established to provide accurate medical service and thereto improve public health. It was set up at three levels, at central and provincial levels, and the subordinate medical services to support and coordinate the functions at the local level. Further, a public health commissioner and a statistical officer were appointed for the overall administration and supervision of the functions of these bodies.

Later, in 1869, the medical departments which were priorly administered in the three presidencies of Bengal, Madras, and Bombay conglomerated with the Indian Medical Service. The recruitment to the Indian Medical Services was through a competitive examination conducted in London. The prime health care and the military and civil surgeries in the presidencies were supervised and headed up by the European officers of the Indian Medical Service. However, recruitment and appointment of these European officers had huge financial repercussions added to that; they required supporting staff, trained assistants, or apprentices such as medical practitioners, compounders, and nurses to ease their services. These implications provoked the British Government to advance establishing or founding an organized system of medical education in India.

[32] See Page 3, At para 5

In 1835, the aboriginal Medical Institutions which imparted teachings and trained generations in the Indian indigenous system of medicine were abrogated, and the classes held at the madrasa and Sanskrit Colleges were suspended indefinitely. These native colleges were replaced by the new medical colleges established by the British Government to educate and train Indians in the European system of medical care. The educational program at these institutions was in the language of English and strictly was in accordance with the modus operandi adopted and followed in Europe. In short, the royal patronage of the primitive and indigenous system of medicines that prevailed in India was taken away. Calcutta Medical College, which was instituted in 1835, was the first new Medical College under British India to set a new phase to the Indian medical education. The young Indians aged between 14 and 20 years were preferred and trained in these colleges, the selection was through a preliminary examination, and they had to undergo rigorous training not more than six years and not less than four years. After the years of training, they had to sit for a final examination, and the successful candidates who pass the said final examination will be given certification, which appropriates the students to practice medicine. These successful candidates will be further appointed as “native doctors" and are eligible to enter the public service.

During mid of 17th century, India witnessed the massive death of local people in Bombay due to lack of adequate medical care and deficiency in medical services, which prompted the then Governor of Bombay, Sir Robert Grant to implement his idea to equip the Indians in Western medicine and to build much organized medical colleges for the same. Though initially, he faced strong resentment, the Medical and Physical Society of Bombay, which formed in 1835 a collective response to encourage the spirit of scientific inquiry, eased his way to reach his goal. The said society headed by Dr. Charles Morehead attempted to research and educate themselves about the attributes or reasons for the abolishment of the indigenous medical school. In 1837, the society came up with the report that the replacement of the new medical colleges was crucial to educate the Indian population in advanced medical sciences in order to mould them into prudent and safe practitioners who could assist the European officers.

IV. The Historical Development or Evolution of Legislations Governing Medical Negligence in India:

Man is the highest form among all the creations of God with the power of discrimination still; a man's action is subjected to mistakes, faults, carelessness, or Negligence. Several ancient scriptures contain laws and rules pertaining to the concept of medical Negligence; for instance, Vivada Ratnakar stipulates the laws regarding Negligence and medical Negligence in the ancient text Vyavaharakalpataru[33]. This heading will be detailing the evolution and development of the concept of medical Negligence that took place from Ancient India to the present.

In Ancient India:

Manusmriti: In Manusmriti (800 CB-600BC), there are explicit verses pertaining to medical Negligence. Manusmriti dictates comprehensive measures for safeguarding the sick person from the imprudent and irresponsible physicians[34]. It mandates that irrespective of caste, creed, religion, and gender, all medical physicians who treat their patients wrongly or negligently, shall be held responsible for their imprudent act and liable to advance compensation. The penalties levied on such negligent acts are depended on whether a human or non-human is the sufferer, which means that if the victim is an animal, then the fine imposed shall be the lowest, and if it is a human, the penalty will definitely fall on a higher rate[35]. In matters involving Negligence by physicians, the penalties or retributions awarded by the king vary depending on the severity of the damage caused by such wrongful act and all other accompanying circumstances.

Yajnavalikya Smriti: Similarly, Yajnavalikya Smriti (300 AD – 100 BC) and the Vishnu Smriti also advocate penalties or compensations for the wrongful treatment by the physicians. Like Manusmriti, it also states that the decree or quantum of penalty should be fixed based on whether the victim is animal or human. Unlike Manu, which states that the class of the victim is also shall be taken into consideration, i.e., the higher the social class or community the victim belongs to, the higher the penalty that will be levied, Manu never advocated class-based penalties. It also prescribes retribution for the adulteration of medicines.

[33] K.P.S. Mahawar, *Medical Negligence, and the Law*, 20 (1991)
[34] Manusmriti, IX.284)
[35] ibid

Kautilya Arthashastra: Arthashastra, the most influential ancient treatise, has meticulously defined the laws or rules regulating the practice of Ayurveda; it comprehends the legalities pertaining to medical science and medical knowledge. Kautilya opines that physician shall seek Permission from the crown before they commence their practice in medicine. Arthashastra mandates that a physician shall be held liable and be punished for his wrongful or negligent act towards his patient during the treatment[36]. Further, physicians are subjected to penalization if they attended a patient and initiated the treatment without informing the concerned authorities or administrative authorities termed as ‘Gopa' or 'sthanika.' Thus, physicians were duty-bound to inform and seek Permission from such administrative officers regarding attending a new case as well as furthering the treatment or curing. Arthashastra is the first-ever ancient treaties to provide for an elaborative code of ethics for physicians. It dictates that in of an illness or disease which is a threat to the life of the patient, then the physician is responsible for informing the same to the concerned authorities. Further, in such circumstances, if the patient died while under the treatment of the physician, then he is supposed to advance a minimum fine, but the reason for the death is a fault or imprudence act on the part of the physician, the punishment will be the highest one and a heavy penalty will be imposed[37]. Arthashastra contemplates that the physician is accorded with a divine duty of care towards his patients.

Naradsmriti: This ancient text contains stipulations regarding 'breach of a promise.' It has direct versus which states that if a physician promised or given an undertaking to perform any obligations or services and failed to does the same, it is regarded as a breach of a promise.

Brihaspati smriti: Brihaspati smriti (200AD-400AD) is an ancient text which elaborately enunciates civil and criminal law. It is the only primitive scripture that describes the offenses along with their respective punishments with much clarity. Brihaspati smriti defines medical Negligence as follows “that is when a physician without having much knowledge about the medicine and the treatment and also ignorant

[36] P.C. Dikshi, *MV Cox's Medical Jurisprudence, and Toxicology*, 11, 7th edition 2002
[37] Kautilya Arthashastra (4.1.56)

of the disease or not capable of judging a disease, obtains any monetary or any other benefits from the patient is unlawful and thus, he shall be regarded as a thief and punished in a similar way.[38].

Ancient India had its own set of certain core principles and legal frameworks which governed and regulated the profession of medicine. Delimiting or curbing the freedom of physicians to practice and imposing restrictions were some of the ways in which the medical profession was controlled in ancient Indian society. Various verses and passages in Sushruta Samhita and Charaka Samhita are proof of the existence of the above-said regulations in ancient times. For instance, Sushruta Samhita mandates that any physician, before beginning any treatment or attending an illness, shall obtain consent from the king for the same. Without the practical training and guidance from a senior or expert physician, no candidate is regarded as qualified or eligible for the actual practice of medicine. Further, after the training, they should practice various objects before they execute their knowledge on human bodies.[39].

In Medieval India:

The Unani system of medicine is of middle eastern origin, and thus, it is the Arab who introduced the same to India. Medieval India under Islam rule was regarded as the golden times for Unani medicine as well. It is this period the Delhi Sultans, the Khiljis, the Tuglaqs, and the Mughal Emperors granted official patronage to the scholars of this system of medicine. During the Islamic rule, there was a highly systematized and established system of examinations and registrations of physicians who practices the Unani medicine. Consent or Permission from the ruler was again mandatory during this period as well. The ‘inspectorate' was appointed to supervise and scrutinize the administration of the system and to keep an eye on the malpractices such as the sale of dangerous and spurious drugs, providing low-quality medicines, drug adulteration, etc. During the rule of Abbasi's, the then Army General Afseen strictly interdicted the sale of certain dangerous or life-threatening drugs further, the 'Ehtisaab' who is an independent officer, was appointed to administer the public health and to check on the

[38] Brihaspat-8-360
[39] Citation- Sushruta Samhita (1-9).

standard and quality of medicine and medical care advanced in the territory. The author Ammavardi (1058 AD) has penned an entire book named Kita-Al Ahkamus Sultania about this designation 'Ehtisaab.' He dictates in the said book that the Ehtisaab is basically an auditor, who are appointed to scrutinize even the prescriptions provided by a physician to his patients. Further, he also has to penetrate as to whether the illness or disease is accurately diagnosed and the medicines prescribed are proper and legal. In short, Ehtisaab's prime function is to ensure proper and accurate public medical care, and there is no carelessness or imprudence on the part of physicians while they advance their services.

In the 10th century death of a patient due to Hakim's[40] Negligence triggered the Abbasi Caliph Mukhtadir Billah, he called for an examination to all the Hakims, and those who could succeed in the exam were only allowed to further or continue their practice.

British India:

During the period, initially, there were a smaller number of physicians or practitioners of the western medicine system compared to that of the Indian population; as mentioned earlier, the reason was original, the European officers brought from Britain were allowed to provide health care in India. In addition to those patients or stakeholders among Indians for the western medicine were also very limited at the beginning; however, in due course of time, there was an increase in the users of Western medicine. The establishment of the new medical colleges and hospitals, withdrawing the official patronage on the indigenous medicines, oil the wheels of practitioners of western medicine to gain supremacy over the physicians of indigenous systems. British Government in India contemplated having legislation against the illegal practice of Western medicine, especially to curb the practice of such persons who acquired knowledge in western medicine not through proper channels or without gaining fundamental training and ability.[41]. Thus, they enacted the British medical Act of 1858, which established the British medical register. The act of 1858 dictates that admission to the medical register is allowed only for those who are holding proper certification or

[40] A doctor, especially one who practices traditional medicine, in predominantly Muslim culture.
[41] Alan Gledhill, *The Republic of India, the Development of its laws and Constitution*, 359 2nd Edition,1964

diplomas awarded in any part of the empire and duly permitted to practice by any local law and also having British acknowledgment about their competence.

It is through the enactment of the Bombay Medical Act, 1912, systematic registration of qualified practitioners in western medicine took its form. The Bombay council has empowered to terminate a practitioner's registration or remove his name from the register roll after an adequate inquiry on account of conviction of an offense involving professional misconduct or moral turpitude.[42]. The enactment of the Indian Medical Councils Act, 1933, greased the wheels to set -up the Central medical council for India. The Medical Degree Act, 1916 administered and regulated the system of advancing degrees and diplomas to practice western medicine. The Medical Degree act mandates that only institutions which are authorized by the British Government can grant degree and diplomas to the candidates of western medicine, the attempt of unauthorized institutions to do the same is unlawful and will be subjected to sanctions. Further, any person who poses a false representation of owning any title or description which alludes that the person is authorized to practice western medicine is also liable to penalties or conviction.

In view of strengthening the practice of Dentistry through educating and train physicians practicing dentistry, the British Government in India enacted the Bengal Dentists Act, 1939. It was the first-ever act that came into force with such a unique aim towards the practice of dentistry. Prior to this act, there were no such provisions for the training of dentists, and there were no restrictions or check on the practice of dentistry without proper training and guidance. In 1912, for the first time, the central British Government of India accorded the provincial Government to select their choice of sanitary commissioners, eight deputy commissioners for the provinces, and also Health officers for each province and to grade all of them in accordance with their qualifications for a better and balanced administration of health care at centre and at provinces[43]. Till mid of 19th century, under the Government of India Act, provincial Governments were vested with the administration and responsibility of medical care and public health for respective provinces. Later, under the Government of India Act,

[42] Ibid
[43] V.B. Singh, *Economic History of India*, 1857-58, 707, (1st Edition. 1965)

1935, there made amendments, as Medical and Public health remained a state matter, but this time the heads of the provinces were made answerable to the Central Authority for medical care and sanitation. Importantly, under British rule, the punishment or liability for professional misconduct or Negligence from the physician was dealt with in accordance with the law of tort, and the concept of Negligence or Medical Negligence was similar to that of English Law.[44].

V. The Indian Medical Degrees Act 1916:

After the establishment of new medical colleges and hospitals to train the Indian population in western medicine, there was a need for an exclusive legal framework to regulate and administer the functioning of such medical colleges and hospitals and services advance by the practitioners. Indian Medical Degrees Act of 1916 took birth to govern and regulate the physicians or practitioners who are trained in the western system of medicine which consists of allopathic and antibiotic medicines, obstetrics, and surgery. Section 2 of the Indian Medical Degrees Act of 1916 explicitly excludes the practitioners of Indigenous systems of medicine such as Ayurveda, homeopathy, and the Unani or Yunani system. Further, section 4 of the Indian Medical Degrees Act 1916 strictly prohibits the practice of providing medical Degrees and diplomas in an unauthorized manner or granting such degrees by any other institutions other than authorized by the British Government is regarded as unethical and is punishable with fines up to five hundred rupees.[45].

VI. Post – Independence India:

When India gained Independence in the year 1947 from the blister rule of the British, it brought not only freedom to live and personal liberty to Indians but also the freedom to lead a healthy life and to avail themselves of a medical system of their choice. The exit of the British from India was a new start for an unwavering journey of advancing medical care in India. The Interim Government, which came into force immediately after the exit of the British, held a conference of the Central and State Health Ministers;

[44] Bolam V. Friern Hospital Management Committee (1957) 1 WLR 583
[45] Indian Medical Degree Act 1916, Section 5&6

this meeting was so crucial as it provided a bigger picture of the country's position with regard to health requirements and needs of its population and it also gave the Government an idea about the kind of strategies to be implemented in order to meet such needs and requirements. The second health conference was held in 1948, which dictated opinions and suggestions regarding the training of medical and supporting personnel and also about organized maintenance of the All-India Medical Register. The Indian Medical Council Act of 1956 repealed and replaced the Indian Medical Council Act, 1933 and facilitated the establishment of the Central Council of Health. Para thirteen of the Code of Medical Ethics, under Indian Medical Council Act 1956, stipulates an important duty of a physician towards his patient that is, under any circumstances, “the patient must not be denied of medical aid or neglected."

Another important milestone of Independent India in the health care system was that the Government of India took the initiative to re-acknowledge the Indigenous system of medicine such as Siddha, Ayurveda, and Unani in parlance with that of western medicine. In 1964, a statutory body was formed to create laws and legal frameworks regarding the manufacturing of Indigenous medicines and their quality. Further, in order to analyze the issues and challenges encountered by the healthcare sector, various committees and commissions were formed by the Government. The core fundamental functions of these commissions and committees are to monitor and analyse the functioning of each state with regard to the public health care and services in both rural and urban areas and to give its recommendations for furthering the developments while mitigating the challenges faced by the health care system.

VII. Committees and Commissions:

In India, the post-Independence was a real-time saga of advancing and bettering the health care system. Indubitably, the enviable recommendations and suggestions of various committees chaired by several intelligentsias of the country also aided in the development and progress of the health care system.

The first committees to form to analyse and study the issues and challenges in the health care system were the Health Survey and Development Cooperation or Bhore Committee and Sokhey Committee. There were numerous committees formed in the

post-independence period which became the bedrock for the development of the health care system in India, such as, Mudaliar Committee, Mukherjee Committee, Chadha Committee, Karta Singh Committee, Mehta Committee, Bajaj Committee, Jungalwalla Committee, Mashelkar Committee. Later, National Commission was established for balancing and administering the macro-economy and health care system.

i. Health Survey and Development Committee 1946 or Bhore Committee:

In 1943, the Government of India appointed the Health Survey and Development Committee, chaired by Sir Joseph Bhore. The prime function of this committee was to analyze and assess the condition of the health system in post-independence India. The other chairs of the committee were decorated by various pioneers in the sphere of healthcare or the medical care system. After a thorough study and research of two years, the committee successfully submitted the report in 1946. The four-volume report of the committee presented a proposal for a national program of health service in India. It also upheld the importance of the concept of preventive care along with the traditional method of curative treatment. It opined that there is an urgent need for rapid socio-economic development, and the same is inevitable to achieve an established health care plan. The all-encompassing and far-reaching recommendations focused on a pro-active medical practice; thus, then it is strongly recommended for a medical system that is a blend of preventive and remedial medical activities to achieve maximum results.

The Bhore Committee had envisioned the concept of national health care services, which would be reaching each of the population irrespective of the geographical, infrastructural hindrance, and the ability to pay for it. The Bhore Committee report, though nearly a century old, facilitated us with a platform or foundation on which we can definitely manifest the mechanism of a national health service[46]. The Bhore committee also attempted to analyse the post-war conditions of other countries as well. The committee, in its report, referred to the instance of post-war Europe, which had been subjected to mountainous change, and the expansion as a welfare state was commendable. Europe was successfully re-established a systematic and well-organized

[46] Ravi Duggal, *Bhore Committee (1946) and its relevance today*, 58(4): 395-406, The Indian Journal of Pediatrics, 1991

health care which is accessible and affordable by the whole population. In short, the bore committee reassured the Government that building an accessible and affordable healthcare system is possible in a post-war condition as well, if there are many strategized and far-reaching efforts paved for the development of the health care system in India.

The prime recommendations of the Bhore committee[47]:

- Consolidation of the preventive system of medical care and curative medical system at all tiers of administration.
- To design a program for the melioration and bolstering of the health care system, especially at the primary level.

Short-Term Agendas and Programmes under the committee

- Setting up Primary health centres in remote and rural parts of the country. Which could cater easy access to fundamental medical care for about 40,000 inhabitants.
- The strategized pattern for the primary healthcare put forth by the committee are as follows: Four public health nurses, Four trained ground workers, two doctors, and one nurse, two well-equipped health professionals, four public health nurses, one pharmacist, two sanitary inspectors, four midwives, and 15 other class IV staffs.

The 'Three Million Plans' or Long-Term Agendas

- Under this scheme, the primary segment should have an accurate and adequate ambulatory service to connect to the secondary level care during a situation that demands the requirement of the secondary level of medical care.
- There should be seventy-five beds in every primary health care centre to accommodate the ten to twenty thousand population of a rural setup.
- Need to establish the secondary level of health centres with a capacity of 650 beds
- Health care centres or hospitals at the district level with a capacity of 2500 beds were other milestones set out in the long-term agenda.

[47] Vikas Bajpai, *"The Challenges Confronting Public Hospitals in India, Their Origins, and Possible Solutions", Advances in Public Health*, vol. 2014, 27 pages, 2014

- These Long-Term programs advised significant changes in the structure of medical education. One of the prime changes was the institution of three months course of 'social and preventive medicine.

One of the prime objectives of the committee underlines that without the backing and support of the medical, paramedical, and auxiliary professionals such as dentists, nurses, and pharmacists, the promotion and strengthening of the health care sector in India is impossible. Thus, there should be provisions that enable and ensure the participation and representation of such professionals, which in turn could influence the health policies and related laws of the country.

ii. Mudaliar Committee

As an initiative to survey the implementation and progress effectuated in health since the submission of reports by the Bhore Committee, the Government of India instituted a 'Health Survey and Planning committee' in the year 1959[48]. The committee was instituted towards the end of the second five-year plan to assess the progress or condition of the healthcare sector after the implementation of recommendations made by the Bhore committee. This committee which chaired by Dr. A. L. Mudaliar keep its scope huge and also submitted detailed recommendations, though it did not give much focus into the merits of its crucial recommendations, but did focus on the legislation aspect of the recommendations. The committee which submitted its report in the year 1962, realized that the level of progress achieved in the healthcare arena was deplorable and disappointing. The findings of the committee were realization of the pathetic and unsatisfactory conditions in primary health centres, and the committee opined that strengthening and intensifying the existing primary health centres is the need of the hour rather instituting new ones. Boosting up of district and sub divisional hospitals was another crucial recommendation. The committee also impressed that a Primary Healthcare centre shall not be constructed to accommodate not more than 40,000 population and also the curative, diagnostic, preventive and other primitive services mandatorily available, and made accessible at each Primary healthcare centres[49]. The

[48] https://www.nhp.gov.in/mudaliar-committee-1962_pg

[49] Report of the Health Survey and Planning Committee (Volume I), https://ruralindiaonline.org/en/library/resource/report-of-the-health-survey-and-planning-committee-volume-i

Mudaliar Committee also opines for an ‘All India Health Services' which is a similar set up that of an ‘Indian Administrative Service' in order to replace and substitute the Indian Medical services[50].

iii. Introduction of the Concept of Public Health Model

As the Mudaliar Committee was appointed to provide a follow-up on the level of progress in health care sector after implementing the recommendations of Bhore Committee. As a response to the task allocated, the committee stressed the point of establishing an all-embracing and unified legal framework for public health and also introduced a concept of Public Health Model. The draft model was very much responsive to the existing health or social problems in a consolidated manner. Many of its crucial recommendations or suggestions are so apparent in the administrative aspects of the testing and repairing work, but majority of them are still not followed or implemented. It was claimed that this draft framework is the first ever which had the core goal at instituting the social machinery to facilitate the citizens an average standard of maintenance in the preventive, curative, rehabilitative and promotion arena of health. This draft framework acted as a legislative counterpart to execute and implement the entire suggestions and recommendations proposed by the Bhore Committee and Environmental Hygiene Committee purported a comprehensive and consolidated health care sector governing all the fundamental fields.

The draft framework aimed not only to make legislations with regard to emergency medical care, but also attempted to manifest a propaganda for such services, which is more focused in the after effects and results and conducting surveys for the same[51]. The duties, obligations and powers of the local governing or concerned authorities were also enshrined in the proposed draft. Under the proposed framework the designated authorities were supposed to trained to help the local authorities in the aspects of funds and technical know-how. The draft legal framework also conferred powers upon the authorities under the act to supersedes the local authorities at certain places. Further, the committee through its proposal draft opined that one third of the earnings of the

[50] CARBALLIDO CORIA, Laura. The Mudaliar Committee (1962): Assessing the beginnings. Estud. Asia Áfr, vol.55, n.3, pp.571-598. Epub 13-Nov-2020. ISSN 2448-654X. https://doi.org/10.24201/eaa.v55i3.2597

[51] SEN, GITA. "Universal Health Coverage in India: A Long and Winding Road." 47, no. 8 (2012): 45-52. Economic and Political Weekly, http://www.jstor.org/stable/41419899

municipality or the local government and one fifth share from the income of non-municipal authorities should be reserved for the development of public health. The extraordinary fact is that this proposed legislative framework did not limit themselves to the government primary sectors and local medical facilities.

VIII. Conclusion

In this 21st century, indubitably healthcare sector is regarded as an industry, and of course, a source of the national economy, and the same has been outgrown over the national boundaries in the name of medical tourism. In other words, the nomenclature "doctor" and "hospital" has been ultimately replaced by the term health care providers in the ambit of commercialization and globalization of medical care. Further, consideration became the prime factor for receiving standard medical care; the higher you pay, the higher will be the quality of medical care. With the evolution that had happened to the health system and the concept of Negligence, it is apparent that the advancement and modernization in the health care structure increased the risk factor and complications tagged with the medical sciences. Thus, there took the birth of the concept of medical Negligence; the doctors who were once treated as God by society became demons through the act of Medical Negligence and malpractices. Howbeit, we should not forget the fact that doctors are also human beings and one among us and so mistakes and faults are do possible on their part; despite the fact that they have grabbed reasonable care, they may make errors or may flunk to execute their duties.

A Negligence suit bears the potential to hammer a doctor in many ways. Through such suits, they have been exposed or vulnerable to the scrutiny of the judiciary, the media, their own co-doctors, and ultimately by the society and thus leading to crippling their career recourse. However, such scrutiny and castigations are inevitable to curb intentional malpractices and grave Negligence; though the medical errors are regarded as the bi-product of the medical profession in order to prevent such grave issues, the collective support of medical professionals of all genres is essential. Doctors shall always be conscious and vigilant. Providing comprehend communication and transparency with regard to the nature and severity of the illness and its respective treatment to the patient, proper and systematic documentation, and maintenance of patient records. Equipping themselves with the latest medical inventions, most

importantly abiding and practicing the standard of care, are the basic fundamental measures to stymie the trivial Negligence suits in medical practice.

Considering the increasing medical Negligence litigations in India, there shall be an initiative on the part of the government to mitigate these confusions. There is a high demand for a new provision or a separate legal framework that could expediently, accurately, and judiciously settle the matter. The next chapter will be discussing the legislation or legal provisions and Enactments, which deal with Medical Negligence in India, and to what extent they could facilitate justice to parties in a Medical Negligence dispute.

Chapter 3: Legislations, Legal Provisions, Enactments Regarding Medical Negligence in India

I. TABLE OF CONTENTS

INTRODUCTION

This Chapter will deal with legislations in India for medical negligence under three heads: Civil Remedies under The Consumer Protection Act, 2019, tort law and Criminal Liability under The Indian Penal Code, 1860 and The Evidence Act,

"*The finest of all the arts, medicine is now lagging far behind all the others, mostly due to ignorance on the part of people who practise it, as well as the foolishness of those who make a judgement on them without considering the consequences*."

-Hippocrates.

Two and a half millennia later, the remark of the father of medicine is still relevant and accurately describes the present condition of the medical profession in India. While it has always been regarded with awe and reverence since the beginning of time, the noble profession today is seen as one that arouses ignoble emotions in certain members of the public, as has been the case for thousands of years.

In recent years, there has been an alarming increase in the number of complaints made by patients claiming medical malpractice with consumer dispute resolution organisations, with a substantial percentage of these instances resulting in an order for compensation being given. There were also a number of cases when criminal charges were brought against medical professionals for allegedly contributing to their patients' demise via their negligence. The rapid increase in medical malpractice lawsuits may be linked to a greater public awareness of an individual's constitutionally protected civil rights as a result of the recent election. International agreements, the Indian Constitution, and the Supreme Court of India, in a slew of health-related decisions, have increasingly recognised healthcare as one of the basic rights guaranteed by the Constitution.

This phenomenon indicates a rising contradiction in our society between the ethics of trust and the rights of individuals, which is closely aligned with the scenario that exists in industrialised nations. Furthermore, the medical profession in India has fallen short of meeting the public's need for greater responsibility from its practitioners. The Medical Council of India did not execute the powers conferred on it by the Indian Medical Council Act, 1956, and it did not impose discipline among medical practitioners as required by the Act of 1956. Because of this, civil society developed a method of fulfilling the need by bringing lawsuits against medical practitioners under criminal and consumer law. In line with the well-established reality that

professions change in reaction to societal forces, often in ways that are in contradiction with the stated and intended goals of their members, this is a positive development.[52]

A. Accountability of Medical Professionals

Since the beginning of mankind, medical practitioners have always been held responsible to the rule of law in the same manner that any other citizen would be held accountable. The methods by which they were held accountable, on the other hand, differed from civilisation to civilization. To what degree is the medical professional subject to the laws of his or her country? Where does he stand in terms of authority, responsibility, and accountability, or answerability or answerability to others? Are the restrictions clear, fair, and reasonable? Is the legislation sufficiently enabling and free for physicians to practise their profession? Each and every person – and particularly professionals – must be held responsible, and the law is one way by which responsibility to the patient, his or her family, and society may be discovered and enforced.[53] These are the kinds of issues that have long preoccupied the thoughts of jurists, health-care professionals and managers, and members of the general public alike.

"*A physician owes each patient the duty to exhibit and bring to bear on the patient's behalf the level of knowledge, skill, and care that would be expected of a reasonable and prudent practitioner under identical conditions, given the current state of medical expertise and available resources*." This cannot be contested. No rational individual would ever knowingly and voluntarily accept anything less than that level of care. According to the Journal of the American Medical Association[54], the following extract highlights a fact that the medical profession should recognise: "*We are all human, and we must and do make errors in diagnosis and treatment. As a result of the complex and inadequate facts on which doctors must base their decisions, errors are unavoidable in the medical field. No one, with the exception of the charlatan, is always correct. Our carelessness and lack of average competence, on the other hand, may be justified in holding us liable, since they are mistakes that any competent practitioner has the ability to avoid*."

[52] Karunakaran Mathiharan, *Supreme Court on Medical Negligence*, Vol. 41 No. 2 ECONOMIC AND POLITICAL WEEKLY, pp. 111-115 (Jan. 14-20, 2006).
[53] Samuels. Alec, *'The Doctor and the Law'*, Vol 49 (4), THE MEDICO-LEGAL JOURNAL, p 139 (1981).
[54] *Id.*

B. Civil Liability under Consumer Protection Act, 2019

As stipulated in Section 20(a) of the Indian Medical Council Act of 1956[55], as modified in 1964, rules issued by the Council may define which breaches would be considered misconduct. Doctors who engage in this kind of professional misconduct may be subjected to disciplinary action, which may include suspension or even expulsion from the medical community.

This setup does not have the intended deterrent impact since Council members have a tendency to be lenient with their conferees, which makes it ineffective. Second, the Council was only present at the State Headquarters, which made it inaccessible to the vast majority of patients who lived outside the state. In any case, the Council does not have the authority to compensate the patients for the injuries they have suffered.

There are provisions in both civil and criminal law that provide remedies to patients who have been wronged. However, criminal law was only called into action in situations of death, and even in such instances, the prosecution was not always on the lookout. In theory, a civil law remedy was accessible since any subordinate court may be addressed for the purpose of recovering damages. Patients, on the other hand, are required to pay court costs. The trial dragged on for a long time because of the complex rules of procedure and stringent evidentiary standards that were in place before those courts. This resulted in a significant amount of time and money being spent, which discouraged the afflicted patients. As a consequence, the physicians were virtually guaranteed protection in the event of wrongdoing on their part. However, it should be noted that their group as a whole exhibited much better behaviour than other corps.

There has been a significant shift since the introduction of the Consumer Protection Act, 1986, which has since been superseded by the Consumer Protection Act, 2019 (hereinafter mentioned as the "CPA"), which established consumer dispute settlement forums on district, state and national level.

According to Section 42(11) of CPA, any issue involving medical negligence on the part of the service provider would be deemed a defect.

In the case of Indian Medical Association vs. V.P. Santha and others[56], after delving carefully into the terms of the Consumer Protection Act, the Supreme Court determined that the wording

[55] Indian Medical Council Act of 1956 (102 of 1956), § 20.
[56] Indian Medical Association v. V.P. Santha and others, (1995) SCC (6) 651.

employed by the legislators was broad enough to include the services provided by physicians as well. In reality, according to the CPA, all services, with the exception of those that have been specifically excluded by the Central Government, will fall within the scope of the Act. According to Section 3 of the Consumer Protection Act, 1986, the availability of alternative remedies will not prevent a consumer from bringing a complaint before the adjudicative bodies established under the Consumer Protection Act. The same is true under the new CPA.[57]

Additionally, CPA specifies that medical services are included in the scope of services as defined in section 2(42). Important to note is that under Section 2(42) of the Consumer Protection Bill, 2018, the previous form of the Consumer Protection Bill, which was approved by the Lok Sabha in 2018, the term "healthcare" was added. However, in its present form, the CPA 2019 does not contain the term "healthcare" under Section 2(42), which gives the definition of the term "service." The Healthcare Amendment, sometimes known as a "technical amendment" and commonly referred to as such, was presented in the Parliament in order to remove the term "healthcare" from the list of services. In response to the outcry from medical professionals and communities, the CPA was enacted to protect them from being victimised by consumers if healthcare services are included in the definition of a 'service' under the Act. Specifically, the CPA established an interpretive loophole relating to the inclusion of healthcare as a service, which will be subject to court interpretation.

The government officials have repeatedly stated that the aforementioned modification in the definition of healthcare would not prohibit consumers from contacting Consumer Forums in the event of medical negligence or a deficit in healthcare services in any way.

Section 2(42) of the CPA contains the phrase "includes, but is not limited to," and the phrase "includes, but is not limited to" is a clause that is inclusive. It specifically draws attention to the fact that the term "healthcare" may still be included and construed under Section 2(42) of the CPA. In this regard, the alleged comfort given to medical professionals by means of a deftly adjusted definition is nothing more than a deluded alleviation that will undoubtedly lead to a slew of questions and uncertainties in the interpretation of the aforementioned clause.[58]

[57] Priya Adlakha, Nihit Nagpal, *India: Medical Negligence India*, MONDAQ, 29 April 2021, available at: https://www.mondaq.com/india/dodd-frank-consumer-protection-act/1062944/medical-negligence-india.
[58] Smita Paliwal, Gaurav Singh Gaur, *India: Exclusion Of 'Healthcare' From the Definition Of 'Service': A Delusional Relief for Medical Professionals*, MONDAQ, 11 August 2020, available at: https://www.mondaq.com/india/healthcare/975294/exclusion-of-healthcare39-from-the-definition-of-service39-a-delusional-relief-for-medical-professionals.

Additionally, any individual who has been harmed by medical malpractice may file a claim for compensation against a doctor or a hospital. A complaint for medical negligence must be submitted within two years after the date of the damage, according to Section 69(1) of the CPA.

Services supplied under a contract of personal service and services provided free of charge are two examples of exclusions granted by Section 2(1)(42) of the CPA (section 2(1)(o) of the old act), which are described below. "*Since the contract between the doctor and the patient was a contract for services rather than a contract of personal service, the Supreme Court determined that the relationship between them was one of master and servant. As a result, any complaint about a medical treatment received after paying for it may be filed before the authorities established by the Act. Although the Supreme Court ruled that a token payment did not constitute consideration, it concluded that the service should be deemed free of charge and thus outside of the jurisdiction of the agencies under the Act, if just a token contribution was given*".

The CPA provides patients with significant relief, which is primarily based on the notion of inadequacy in service delivery. Specifically, it is defined as follows in the Act under section 2(11): - "*A defect, imperfection, shortcoming, or inadequacy in the quality, nature, or manner of performance that is required to be maintained by or under any law currently in force, or that has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service is referred to as a deficiency*." When it comes to the definition, there is a mention of law and contract. With the exception of a few clauses, there is no legislation in this domain. In addition, although if the parties are in a contractual relationship, there are often no formal terms of contract between them. As a result, any deficit must be determined in accordance with the canons governing medical treatment procedures. In accordance with established medical practise, the doctor is responsible for delivering the care that has been agreed upon, whether implicitly or explicitly. He must do the task with the necessary ability, knowledge, and competency. The level of care anticipated is consistent with what a typical doctor would provide in the similar situation. Deficiency occurs when the service provided falls short of the required standard of excellence.[59]

[59] Singh G., *Medical Negligence and the widening ambit of the consumer protection Act, 1986 – A comment on spring Meadows Hospital v. Harjol Ahluwalia,* 42(1), JOURNAL OF THE INDIAN LAW INSTITUTE, 78-85 (2000).

A deficiency in treatment, knowledge, or consent may all be caused by a lack of information. According to Section 39 of the Act, the remedy for a defect is either the removal of the deficiency or the reimbursement of the costs.

Two distinct types of remedies that can be availed under CPA in Section 39, the first being for deficit under section 39 (1) (a) & (f) and the second being for damage caused by negligence under section 39 (1)(d). In the event of a doctor's failure or misconduct, patients may request both of the reliefs or just one of them, depending on the circumstances of the particular situation. Whatever is sought must be argued and proved clearly and unequivocally. In contrast to negligence, which is not specified in the Act, deficiency is defined in the Act. Consequently, the meaning assigned to that word under the law of torts shall be followed. As there are certain parallels between inadequacy in service and harm as a result of carelessness, there is a danger of misunderstanding between the two. Despite the fact that reliefs are obviously different from one another, it is essential that they be distinguished from one another.[60]

i.<u>Establishing the amount of compensation due in the event of negligence:</u>

This particular remedy is left to the discretion of the adjudicating authorities, in contrast to the other reliefs, which are all established by the Act itself. The Act is satisfied with stating that the opposing party is obligated to "pay such amount as may be awarded by it as compensation to the consumer for any loss or damage incurred by him as a result of the carelessness of the other party." This implies that the consumer dispute resolutions forums will not be required to calculate the loss precisely; instead, it will award a specific sum based on the totality of the facts of the situation.

As a result of the discretion granted, there has been a great deal of variance from one forum to another in terms of the amount of compensation awarded. Of course, the amount is likely to fluctuate depending on the magnitude of the loss. However, one aspect that should be noted is that for the same damage or loss, the sum granted as compensation has ranged from Rs. 1,000/- to Rs. 10,00,000/-, depending on the circumstances.

The age of the patient, his or her condition of health, the amount of fees paid, and any other information that has been given to the doctor are all variables that are be taken into consideration. Certain injuries, such as physical pain, mental anguish, and loss of quality of life, are difficult to quantify in monetary terms. There are two types of evaluation methods:

[60] Annoussamy, D, *Medical profession and the Consumer Protection Act*, 41(3/4), JOURNAL OF THE INDIAN LAW INSTITUTE, 460-466 (1999).

Global evaluation based on the best judgement of the adjudicating body, which must consist of at least three people, or calculation of damages based on a set of yardsticks are both possible. There is an appearance that the second course is more accurate than the first course. However, it is difficult to identify the appropriate yardsticks, which may lead to serious mistakes in certain cases. Global assessment is currently the preferred method of evaluation by the forums.

In conclusion, with the implementation of the Consumer Protection Act, individuals who pay for their medical services will have more protection. Because their numbers are increasing, it is expected that their coverage would grow as well. However, two groups continue to be barred from participation: those who are refused service and those who are unable to pay for the service. A number of efforts were made to put the final group, which comprises the overwhelming majority of cases, within the jurisdiction of the agencies, but these efforts were rejected as being contradictory to the overall design of the Act. In reality, charitable organisations and government hospitals are able to provide care for this particular group of patients. In both instances, measures must be made to improve monitoring and conduct a therapeutic audit in order to prevent accidents.

As far as physicians are concerned, whatever of their reasons for opposing the Act, there is no disputing the reality that medical services are increasingly being provided on a commercial basis, and that treatment is becoming more expensive. Due to the appeals and revisions procedures that are in place, the adjudicating forums give them with an adequate assurance of fairness. They may also choose to take certain preventative measures. The first is to proceed with caution. They may also abstain from dealing with situations that are outside their scope of expertise and equipment. They will not, of course, turn away a person who is in need of immediate medical attention and treatment. Should an action be brought against a doctor in spite of these safeguards before a Consumer Dispute Resolution Forum, his or her best defence is the case sheet, which has to be maintained up to date and accurately, with notes made at regular intervals about observations and treatment.[61]

Doctors, on the other hand, may still have a genuine resentment. A complaint that is filed may result in negative publicity that may harm the reputation of the doctor who lodged the complaint, even if the case is eventually dismissed. A possible solution would be to require all complaints to be resolved via mediation and conciliation in order for them to be filed with the

[61] SS Rana & Co, *Medical Negligence India*, LEXOLOGY, 27th April 2021, available at: https://www.lexology.com/library/detail.aspx?g=b271f61b-9bc7-4d12-9e88-4c058fd8951b.

agency. Second, medicine may be added as one of the requirements for becoming a member of the forum. In the event that they are given the chance to pass judgement on the actions of other professionals, physicians will come to terms with those who are questioning their performance.[62]

C. Tort law

i. Crime to tort

When medical negligence was regarded a crime rather than a tort in previous centuries. For instance. The Code of Hammurabi, which was written in Babylonia about 20 centuries before the beginning of the Christian era, is the first known document that addresses medical negligence. When a physician performed an operation on a man to treat a serious wound, and the operation resulted in the man's death, the physician's hands were to be severed. Similar severe penalties were meted out by other contemporaneous civilisations in days gone by, as well. "*Medical negligence was also regarded an offence against the state or the general public, for which the state, as the representative of the people, brought procedures to punish the crime. The people were the ones who brought the proceedings. A primary goal of the criminal process is to safeguard and vindicate the interests of the general public by punishing the defender (in this case, the physician) and/or imposing a penalty*." In criminal procedures, the victims were almost always denied any monetary compensation. However, when common law developed in England, this situation experienced a significant shift in significance. Since the fourteenth century, medical malpractice has increasingly been seen as a tort rather than a criminal offence. The tort law varies from the criminal law in that it is mainly concerned with providing compensation to injured patients or their families, rather than prosecuting the irresponsible medical practitioner who caused the injury. "*The next centuries saw the development of negligence law, which was founded on the law of torts*". Thus, in 1838, Chief Justice Tyndall said, when deliberating the issue of a sufficient level of skill and care in a medical malpractice claim, "Every person who joins a learned profession agrees to bring to the execution of that profession a fair degree of care and competence."[63]

The position regarding negligence in civil law is very significant because it covers a wide range of factors in its own right. This concept is relevant under tort law or civil law even if medical

[62] Jyoti Dogra Sood, *Responsibility of Doctors for Rash or Negligent Act*, Vol. 46, No. 4, JOURNAL OF THE INDIAN LAW INSTITUTE ,588 - 592 (2004).
[63] Lauphier vs Phipos (1838) 8 C and p 475: 34 Digest 548; (1835-42), All ER Rep 421.

practitioners offer free services, according to the courts.[64] On the other hand, it may be argued that when the Consumer Protection Act terminates, tort law starts.

Patients who believe that the services provided by a doctor or a clinic do not come within the definition of "services" as defined by the CPA may file a claim against the physician or the facility under the tort law of negligence. When it comes to medical malpractice, the onus (burden of evidence) is on the patient, who must demonstrate that he was injured as a result of the doctor's or the hospital's negligence.

Examples of medical malpractice include the transfusion of blood from the wrong blood group, leaving a mop in the patient's abdomen after an operation, removing organs without the patient's consent, and prescribing the incorrect medication, which results in injury.[65]

"*Medical advice and care professionals implicitly declare that they have the necessary knowledge and skills to do so, that they have the ability to decide whether or not to accept a case, to choose the care, and to deliver that treatment*." When a medical practitioner makes this kind of commitment, it is referred to as an "implied undertaking."

Before any consideration of responsibility can be given, a number of criteria must be met. In order to be found guilty, "*the accused must have done an act of omission or commission, and this act must have been in violation of the accused's duty, and this breach of duty must have resulted in damage to the injured party*." The complainant must substantiate the allegations against the doctor by referencing the most up-to-date medical scientific evidence and by providing an expert opinion from a medical professional.[66] The issue of degree has always been important in determining the distinction between carelessness under civil and criminal laws.[67]

D. Criminal Liability under Medical Negligence

The Supreme Court of India ruled in the case of the State of Haryana versus Smt Santra that every doctor "has a responsibility to act with a reasonable degree of care and skill".[68]

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[64] Smreeti Prakash, *A Comparative Analysis of various Indian legal system regarding medical negligence, LEGAL SERVICES INDIA, available at:* https://www.legalserviceindia.com/medicolegal/mlegal.htm.
[65] Talha Abdul Rahman, *Medical Negligence and Doctor's Liability*, 2(2) INDIAN JOURNAL OF MEDICAL ETHICS, 60-61 (2005).
[66] Dr. Lakshman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole, AIR 1969 (SC) 128.
[67] Sylvine, *Medical Negligence and Law in India – An Analysis*, IPLEADERS, July 18, 2016, available at: https://blog.ipleaders.in/medical-negligence-law-india-analysis/.
[68] State of Haryana v. Smt Santra, 5 SCC 182, AIR 2000.

Criminal responsibility may be imposed under the provisions of the Indian Penal Code, 1860 ("IPC"), which are broad in nature and do not explicitly address "medical negligence." The IPC is a federal statute that was enacted in 1860.When it comes to motor vehicle accidents caused by rash or negligent driving.

For example, Section 304A of the Indian Penal Code[69], which deals with "*death caused by any rash or negligent act and can result in imprisonment for up to two years, is used to deal with both cases of accidents caused by reckless or negligent driving and cases of medical negligence leading to the death of a patient. In a similar vein, other general sections of the Indian Penal Code, such as Sections 374 (causing pain) and 385 (causing severe hurt), are often used in connection with medical malpractice prosecutions*".

In the Santra case, the Supreme Court noted that, although responsibility under civil law is determined by the amount of damages suffered, in criminal law, the quantity and degree of carelessness are considered factors in assessing liability for criminal offences. However, in order to assess criminal responsibility in any given instance, several factors must be proved, including the motivation for the offence, the severity of the offence, and the character of the perpetrator or offender.

The Supreme Court made a distinction between carelessness, rashness, and recklessness in the case of Poonam Verma versus Ashwin Patel.[70] A negligent person is one who unintentionally breaches a positive obligation by failing to do an act that is required of them. A person who is rash is aware of the repercussions of her/his actions, but she/he is mistaken in believing that they will not occur as a result of her/his actions. Any behaviour that does not fall within the categories of recklessness and intentional misconduct should not be subject to criminal prosecution.

As a result, "*a doctor cannot be held criminally liable for the death of a patient unless it can be shown that she or he was negligent or incompetent, and that he or she acted with such disdain for the life and safety of his or her patient that it constituted a crime against the state*".[71]

ii. Defences available to doctors

Several defences are available to physicians who have been charged of criminal responsibility under Sections 80 and 88 of the Indian Penal Code. "*Anything done by accident or misfortune*

[69] Indian Penal Code, 1860, § 304.
[70] Poonam Verma v. Ashwin Patel, (1996) 4 SCC 332.
[71] R v. Adomako, (1994) 3 All ER 79.

and without any criminal purpose or knowledge in the course of carrying out a legal act in a lawful way by lawful means and with appropriate care and caution is not considered an offence under Section 80 (accident in the course of carrying out a lawful act). As stated in Section 88, a person cannot be charged with an offence if she or he acts in good faith for the benefit of another, does not intend to cause damage even if there is a danger of doing so, and the patient has provided permission either expressly or implicitly".[72]

iii. <u>The burden of evidence and the likelihood of mistake</u>

The burden of proving negligence, carelessness, or inadequacy usually rests with the party that is bringing the complaint. An accusation of medical malpractice against a doctor must meet a greater level of proof than would otherwise be required under the law. In instances of medical malpractice, the patient is responsible for establishing the validity of his or her claim against the practitioner.

In the case of Calcutta Medical Research Institute versus Bimalesh Chatterjee, it was determined that the onus of demonstrating carelessness and the resulting defect in service was squarely on the complainant's shoulders.[73] In the case of Kanhaiya Kumar Singh versus Park Medicare & Research Centre, it was determined that negligence had to be shown rather than assumed.[74] Even after following all medical protocols to the letter, a competent practitioner may make a mistake. According to several recent decisions by the National Consumer Disputes Redressal Commission and the Supreme Court, when something goes wrong during treatment or diagnosis, "*a doctor is not held responsible for negligence or medical deficiency if she/ he has acted in accordance with the practise accepted as proper by a reasonable body of medical professionals skilled in that particular art, even if she/ he has not followed the practise accepted as proper by the reasonable body of medical professionals skilled in that particular art*." It is impossible to rule out the possibility of an accident resulting in mortality during different types of medical and surgical treatment and procedures. Due to the doctor-patient connection and the resulting reciprocal trust, it is inferred that a patient is willing to take on such a risk.

When dealing with medical malpractice situations, the views of medical experts are often sought by both the plaintiff and the defendant. Specifically, Section 45 of the Indian Evidence Act (1872) states that in the case of a court having to make an opinion on a scientific issue, the

[72] Amit Agrawal, *Medical negligence: Indian legal perspective*, 1 ANN INDIAN ACAD NEUROL, S9–S14 (2016).
[73] Calcutta Medical Research Institute v. Bimalesh Chatterjee, I (1999) CPJ 13 (NC).
[74] Kanhaiya Kumar Singh v. Park Medicare & Research Centre, III (1999) CPJ 9 (NC).

judgement of a person who has specialised knowledge in that field is deemed "relevant." It should be emphasised that a "relevant" opinion does not always imply that the view is "conclusive," and law reports are rich with examples of expert opinions that were rejected for a variety of reasons. The true function of the expert is to present to the court all of the relevant evidence, together with the reasons that led him to reach a particular conclusion, so that the court, even though it is not an expert, can form its own judgement based on its own observation of the relevant evidence and arguments[75]. Experts simply provide views, and those that are "intelligible, persuasive, and tested"[76] become significant elements in determining the outcome of the case when considered in conjunction with the rest of the evidence. Consequently, while the courts do not substitute their opinions for those of experts, they may find that the course taken by a medical professional was inconceivable or highly unreasonable, in which case they may find that the medical professional was negligent and return a finding of medical negligence.

A first complaint against the relevant individual or people will be filed with the local police authority by the party who has been wronged. After a reasonable amount of time has passed without action, the offended person may file a criminal complaint under the Criminal Procedure Code of 1973.

Medical negligence rules in India are subject to a number of complaints, some of which are pointed directly at the legislation. The first and most important is the concept of 'Burden of Proof.' The plaintiff has the burden of proving his or her case. Consequently, if a patient claims medical malpractice, the law will need more proof to be presented to support the allegation. It becomes very difficult for an ordinary person or a patient to identify the precise nature of the harm and the causal relationship between the injury and the doctor's negligence in this situation.

Therefore, the patient is unable to establish the doctor's negligence beyond a reasonable doubt since medicine is an unpredictable and unexpected area in which anything may happen in a human body at any moment, and the burden of proof shifts to the plaintiff in this case.

[75] Titli v. Alfred Robert Jones, AIR 1934 All 273.
[76] Ramesh Chandra v. Regency Hospital Limited, (2009) 9 SCC 709.

E. Criminal Medical Negligence in India through Supreme Court Cases

Since 1998, the Supreme Court has issued four contradictory orders on the issue of filing charges under Section 304-A of the Indian Penal Code against licenced healthcare professionals for alleged gross negligence in the course of their practise.

In Mohanan vs Prabha G Nair[77], a panel of the Supreme Court ruled that the high court erred in dismissing a civil case at an early stage where guilt could only be proved via a thorough examination of expert evidence presented by the plaintiff was not warranted. It also found that the appellant did not have a full chance to present facts before the magistrate and that the carelessness of a healthcare professional could only be determined by scanning the evidence, if any, and expert testimony.

Accordingly, in Dr Suresh Gupta versus Government of NCT of Delhi[78], the Supreme Court reversed its previous decision in Mohanan's case and issued a new ruling. An appeals court ruled that, in order to establish criminal liability under Section 304-A of the Indian Penal Code against a doctor or surgeon, the standard of negligence that must be proven must be so high as to qualify as "gross negligence" or "recklessness," and not simply a lack of necessary care, attention, and skill. Following the issuance of this decision, on September 9, 2004, a court ruled that the verdict in the case of Suresh Gupta was unconstitutionally harsh. They found that the terms "gross, reckless," "competent," and "indifference" did not appear anywhere in the criteria of "negligence" under Section 304-A of the IPC and thus did not constitute negligence. As a result, they remanded the case back to the lower court for further consideration by a larger panel of judges. This referral is still pending in front of a five-member panel of judges.

Meanwhile, in the case of Jacob Mathew vs. the State of Punjab[79], a three-member panel of the Supreme Court ruled in August 2005.

The principles of law established in the Suresh Gupta case were confirmed by the Supreme Court in this case. In this case, the Supreme Court dealt with the responsibility of a medical practitioner under criminal law, and it went into great depth about the law of medical negligence, as well as the criteria for determining who is responsible. Also emphasised was the difference between the notion of carelessness in civil law and the concept of negligence in criminal law, which was previously overlooked. Furthermore, it has distinguished between

[77] Mohanan v. Prabha G Nair, 8 (2004) 3 SCC 391.
[78] Dr Suresh Gupta v. Government of NCT of Delhi, (JT 2004 (6) SC 238; (2004) 6 SCC 422.
[79] Jacob Mathew vs. the State of Punjab, 1 (2005) 6 SCC 1.

"negligence" that occurs in the course of one's employment (such as a hasty or careless conduct performed by drivers in a road traffic collision) and professional negligence (committed by the professionals).

An accident alone does not constitute proof of carelessness, and a mistake in judgement on the part of a professional does not constitute negligence per se, according to the Supreme Court. The higher the acuteness of the situation in an emergency and the larger the complexity, the greater the likelihood of a mistake in judgement. Due to the professional reputation of the individual is at risk, no reasonable professional would deliberately commit an act or omission that would cause loss or harm to a patient. It is possible that a single failure may lose him his whole career.

The Supreme Court summed up its conclusions as follows:

(1) "*Negligence is a direct violation of a duty caused by the failure to do something that a prudent and reasonable person, guided by the considerations that ordinarily govern the conduct of human affairs, would do or by the commission of an act that a prudent and reasonable person, supported by the factors that normally regulate the conduct of human affairs, would not do*". Negligence becomes actionable when a harm occurs as a consequence of an act or omission that constitutes negligence and is traceable to the person who is being sued. There are three fundamental components of negligence: "obligation," "breach," and "resulting harm." The first two are self-explanatory.

A therapy that is different from standard practise is required in the context of medical malpractice.

(2) Additional factors must be taken into account when inferring rashness or carelessness on the part of a professional, particularly a doctor. A case of occupational negligence differs from a case of professional negligence in that it involves a workplace injury. A mere lack of care, a mistake in judgement, or an accident on the part of a medical practitioner is not evidence of negligence on their side. "*A doctor cannot be held liable for negligence simply because a better alternative course or method of treatment is available or simply because a more skilled doctor would not have chosen to follow or resort to the practise or procedure that the accused follows, so long as the practise is appropriate to the medical profession at the time of the incident*".

(3) A professional may be found responsible for negligence on the basis of one of two findings: either he is not in possession of the necessary skill that he claims to possess, or else he does

not execute, with reasonable competence in the particular situation, the skill that he claims to possess. The standard to be used in determining whether the individual charged with negligence was negligent would be that of an ordinary competent person using ordinary competence in that profession, regardless of the circumstances. In order to practise at the greatest level possible, every professional must have the highest degree of competence or capabilities in the field in which he works. A highly competent professional may be endowed with superior characteristics, but this cannot be used as the foundation or yardstick for evaluating the work of a professional who is being prosecuted on a charge of negligence.

(4) The standard established in Bolam's case[80] for assessing medical negligence remains valid in terms of its application in India.

(5) The notion of carelessness is defined differently in civil and criminal law. The same thing that may be considered carelessness in civil law may not be considered negligence in criminal law. The presence of the element of mens rea is required in order for negligence to be considered an offence. "*It takes a very high degree of carelessness, i.e., egregious or very high degree of negligence, for an act to be considered criminal negligence. Negligence that is neither gross nor of a higher degree may give rise to a civil action, but it cannot be used as the foundation for criminal prosecution*".

(6) Although the term "gross" is not used in Section 304-A of the Indian Penal Code, it is well established that in criminal law carelessness or recklessness must be of such a high degree as to be considered "gross" in order to be so held. The phrase "rash or negligent conduct," which appears in Section 304-A of the Indian Penal Code, must be interpreted as qualifying the phrase with the term "grossly."

(7) In order to prosecute a medical practitioner for negligence under criminal law, "*it must be shown that the accused did or failed to do anything that no reasonable medical professional in his or her usual senses and wisdom would have done or failed to do under the circumstances".* According to the standard of care, the danger taken by the accused doctor should have been of such a character that the harm that occurred was almost certainly impending.

(8) Res ipsa loquitur is simply a rule of evidence that works in the realm of civil law, particularly in the context of torts, and is useful in establishing the onus of proof in proceedings involving negligence. It is not a legal doctrine. The doctrine cannot be used to determine the

[80] Bolam vs Friern Hospital Management Committee, ([1957] 1 WLR 582, 586).

responsibility for carelessness in the context of criminal law in and of itself. When it comes to a criminal negligence trial, the doctrine of res ipsa loquitur has only a limited applicability, if any at all.

Private complaints may not be filed until, in discussions with the Medical Council of India, the Government of India or state governments have issued statutory regulations or executive instructions that incorporate certain guidelines, according to the Supreme Court, unless the complainant has made a prima facie case before the court of a reliable opinion delivered by a field expert. The investigating officer should seek a neutral and qualified medical opinion before prosecuting a doctor accused of being a careless or careless act or omission; ideally, from a doctor in the government service that is eligible for this practise and who can be expected to provide an independent and fair view applying Bolam's case tests to the facts collected during the course of his or her investigations. A doctor's arrest for rashness or negligence may not be done regularly (simply because a charge has been levelled against him). The arrest may be rejected under certain circumstances if its arrest is absolutely essential in order to continue investigating or gather evidence, or if the investigating officer is confident that if he is arrested the doctor under examination would not be able to face prosecution.

Following the decision of the Supreme Court in the case of Jacob Mathew, it was assumed that medical practitioners could not be sued for negligence. As a postscript to Jacob Mathew, the Supreme Court noted in State of Punjab versus Shiv Ram[81] that, whether in criminal prosecutions or tort claims, the burden of proof is always on the side of the prosecution or the claimant. Without a doubt, depending on the evidence shown by either the prosecution or the claimant, a doctor may be required to explain his or her actions in a particular instance. That stance does not alter as a result of the prudence recommended in the Jacob Mathew case when it comes to imposing responsibility for medical malpractice on physicians in the future.

F. Confusion by doctors, role of media and divided judiciary

What causes doctors to be perplexed by the concept of "criminal negligence"?

Patients and doctors alike are subjected to a kind of "trial by media" or "post mortem of a court of law conducted by the media," or to disinformation disseminated via social media and the complexity of legal terms used in the context of "Criminal Negligence." As reported by various leading national news publications following the recent decision of the Supreme Court, "Doc

[81] State of Punjab v. Shiv Ram, 4 (2005) 7 SCC 1.

not criminally liable if patient dies," "Saving the Doctors," "SC Judgment Qualifies Medical Negligence," "SC Insures Docs Against Patient Death," "SC Ruling a Deliverance for Medical Fraternity," "SC Comes to the Rescue of Doctors," and other similar headlines were published. “This would imply that the relief that the physicians had received as a result of the Judgment would be unavailable to them until the bigger Bench has rendered its decision.” Those doctors who rely solely on media reports without verifying the facts from the original judgement or through discussion with legal experts on the subject may fall prey to the misinformation propagated by journalists and spread the same feelings and knowledge to their colleagues and junior doctors, leaving them perplexed on the subject of criminal negligence for the rest of their careers. While the Supreme Court's decisions include no new information beyond reiterating the already known fact that "mistake of judgement is not negligence."[82]

The Impact of the Media: According to the Indian Constitution, Articles 19 and 21 provide implicit protection for freedom of expression and information. Earlier this year, the Supreme Court ruled that the editors of two newspapers had violated court orders by publishing inaccurate and biased news stories. The court stated that "it is the duty of a true and responsible Journalist to inform the people with accurate and impartial presentation of news and his views after dispassionate evaluation of the facts and information received by him to be published as a news item."

Because of this, Indian media has played an incredibly significant role in educating people about government, development, science and technology, international affairs, and other topics since the 1970s. However, as shown by the Supreme Court judgement cited above, it has recently come under fire for a variety of reasons. According to both the Chairman of the Press Council of India and the President of the Republic of India, K.R. Narayanan, there is a decrease in journalistic credibility. Due to the media's preoccupation with trivia, personality cult, one sidedness, and instant in-depth investigation in recent years, 51 senior journalists have expressed their concern that the media is moving away from important people's issues and is becoming a consumer product with a manager taking precedence over the editor. While a legal

[82]Puneet Yadav & Prashant R. Dahat , *Medical negligence and criminal law: An Indian Perspective,* SSRN (2010), available at: https://poseidon01.ssrn.com/delivery.php?ID=724017066103120092113030028099082022026080077013030029112113027026093028106082084073011056033056027005107127090117025066071001046072056061077089127126087104116097089028058087083099115088089030082081090013101016078027074098126120080022009120093098097093&EXT=pdf&INDEX=TRUE.

process is in progress, the media has a propensity to start a "trial by the media," or even a "sentencing by the media," without first consulting the court.

Judiciary Division: The remanding of the Supreme Court's decision to a bigger bench further demonstrates the split view of the court as well as the intricacy of legal terms employed in instances of carelessness. The much-debated decision of the Supreme Court has now been referred to a bigger Bench for review on September 9, 2004, which will take place on September 9, 2004. An IPC Section 304-A definition of death caused by an act of negligence or culpable homicide that does not amount to murder was rejected by a two-judge bench consisting of Mr. Arijit Pasayat and Mr. C.K. Thakkar, who found that the terms "gross negligence" and "reckless act" did not fall within the definition of that section. A tough job for the court is determining the degree of carelessness and negligence claimed on the part of the doctor while deciding between civil and criminal responsibility for a doctor who causes the death of his or her patient. Evidence of carelessness and intentional wrongdoing, along with a greater degree of morally blameworthy behaviour, should be required for the conviction of a doctor for an alleged criminal offence.

G. Conclusion

In conclusion, medical practitioners may be feeling delighted after the Supreme Court's decision in Jacob Mathew. It should be noted, however, that the Supreme Court in Jacob Mathew did not provide any additional concessions to medical practitioners as a result of its decision. It has merely confirmed the employment of a worldwide judicial strategy in adjudicating civil medical negligence cases, as well as its own remarks made in previous judgments[83] on the arrest of a suspect. Furthermore, in the following case of State of Punjab vs Shiv Ram[84], the court issued a caution to medical practitioners, advising them to keep an eye out for their erring business-minded colleagues. It said that, in recent years, self-regulatory standards in the medical profession have deteriorated, and that this may be ascribed to the overwhelming effect of commercialization on the industry. There have been allegations of physicians engaging in exploitative medical practises, misusing diagnostic techniques, brokering agreements for the sale of human organs, and other similar activities. It cannot be disputed that there have been instances of "black sheep" entering the industry, and that the profession has been unable to successfully separate them. In order to complement professional self-regulation, there is a continuous increase in the need for external control. Because of the

[83] D K Basu vs State of West Bengal, (1997 AIR SC 619).
[84] State of Punjab v. Shiv Ram, 6 (2005) 7 SCC 1.

significant expenditures and investments required in the delivery of medical care, it has been transformed into an entrepreneurial activity in which the experts seek to reap the most possible profits on their efforts. Medicine has long had a high regard in society; nevertheless, the balance between service and business is moving alarmingly towards business, necessitating the need for more effective and efficient regulation, whether internal or external. The medical profession, both individually and collectively, must engage in self-examination. As a result, they must rise to the occasion and play an active role in enforcing discipline and high standards across the industry. Consequently, the ball has been returned to the medical community, with an ultimatum to do action to stop the rot that has set in their field.[85]

[85] *Supra* note 52, at 36

We are all aware that every discipline or a system needs laws for it function properly. With the contemporary times and development in the scientific technologies in the area of medical sciences it is important to evaluate the laws while comparing it to the countries that have on of the best set of laws governing the medical health systems like UK and the USA. While this comparison we can also try to understand where we lag behind in terms of medical advancement and laws applicable to it.

A. Introduction to Indian Medical Laws

In India, health care includes a universal healthcare system administered by the governments and territories concerned.[86] Law is a duty of the community imposed by the responsible authority, which may be punishable by a monetary fine or jail or both. The oldest known rule of law, the Hammurabi Code, regulated several elements of the profession, including charges for acceptable services payable to doctors. The Hippocratic Oath, the first known rule of medical ethics, was set by Hippocrates, the Greek doctor, 2500 years ago, in the 5th century BC. The current form of Hippocratic Oath, designed by the WHO after the Second World War (the Declaration of Geneva) is recognised by worldwide medical community.[87] The process of establishing the health system under the colonial administration also required the development of the legal framework for medical professionals. As the number of qualified physicians in Indian medical schools grew, it became essential to establish legislation for them. The Indian Medical Council was established following the Indian Medical Council Act 1933, a national statutory organisation for physicians of modern medicine. When Bombay Medical Practitioner's Act was enacted in 1938, the first legal recognition and registration for the Indian medical systems came into effect.[88]

The hospital commissioning law is the law to ensure that hospital facilities are created after a proper registration process, which the established facilities are scur to the public using the facilities, that they have, for the type and volume of work, at last the necessary minimum infrastructure and that they are subject to periodic inspections to ensure their conformity.[89] Other laws apply to the qualification/practice and conduct of professional people, the sale,

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[86] *Indian Laws and regulations related to health*, MEDINDIA, available at https://www.medindia.net/indian_health_act/acts.asp (last visited on August 10th, 2021).
[87] KOSAMBI DD, THE CULTURE AND CIVILISATION OF ANCIENT INDIA IN HISTORICAL OUTLINE, New Delhi, Vikas Publication 1970.
[88] Indian Medical Council Act, 1933.
[89] *Id.*

storage and safe medications, patient management, environmental protection, employment and workplace management, pharmaceutical aspects and safety legislation, as well as the public and staff in hospital premises, Professional training and research legislation, corporate elements, licenses/certifications needed for hospitals, etc.[90] A hospital administrator should be aware of all these laws, rules, policies, processes, reports and returns, and be informed of the newest changes that must be safe in law and offer patients with high-quality treatment.[91]

B. History and Background

The oldest known civilisation is the urban Indus Civilization from 3000 to 2000 BC. The famous medical historian Henry Sigerist thought that Mohenjo Daro public health services were better to those of any other ancient-oriented society.[92] Since ancient times, those who take up this holy vocation have been assigned specific obligations and responsibilities. Charak's Oath (1000 BC) and Hippocratic Oath are examples of this (460 BC). Written proof of the participation and regulatory role of the State is found in Arthashastra Kautilya. Kautilya regarded starvation as a major disaster than pestilence and epidemics, since illnesses may be remedied. He thought the monarch should instruct the doctor to employ medication to fight epidemics.[93]

The oldest known code of health regulations was Hammurabi, the renowned King of Babylon, created around 2000 BC. This legislation, also known as the Hammurabi Code, regulated many areas of health practises, including the fees due to a doctor for acceptable services. The laws were harsh and damaging treatment punishments strict. Doctors whose suggested treatment has proven incorrect were at danger of death. This was the first medical practise codification.[94]

The Hippocratic Oath, the first known rule of medical ethics, was set by Hippocrates, the Greek doctor, 2500 years ago, in the 5th century BC. Until now, he was regarded as the 'Father of western medicine.' For centuries, Hippocratic Oath has guided and regulated the behaviour of physicians. The current version of Hippocratic Oath (called the Geneva declaration) created by

[90] Calcutta Medical Research Institute v. Bimalesh Chatterjee, I (1999) CPJ 13 (NC), *Indian Laws and regulations related to health*, MEDINDIA, available at https://www.medindia.net/indian_health_act/acts.asp (last visited on August 10th, 2021)
[91] *Id.*
[92] Henry SE, *A history of medicine*, Vol II, EARLY GREEK, HINDU AND PERSIAN MEDICINE, OXFORD UNIVERSITY PRESS, 142-143 (1987).
[93] *Id.*
[94] *Id.*

the World Health Organization after the World War II and approved as the worldwide Code of Medical Ethics by the International Medical Brotherhood, relies significantly on its old oath.[95]

The state expressed interest in public labour and medical treatment and as a legislation during the Ashoka era (270 BC). He built hospitals across his empire at public cost with medical services. 4 Ethics is presented in the Charaka—Samhita and ancient India had a certain medical ethics in detail and Ayurvedic doctors.[96]

The colonial authority brought its own doctors and barber surgeons with them. As medicine was acknowledged in England in the mid-19th century, it eventually began to influence India too. After 1857, their concern for the soldiers and European civil populations was the primary elements that influenced colonial health policy in India.[97]

The process of establishing the health system also required the development of a legal framework for medical practitioners. The doctors and surgeons recruited by the East India Company and the British Government after 1857 required discipline and legislation in the previous era. Colonel of Lt. Crawfords 'History of Indian medical services 1600-1913' tells of the many cases of discipline, insubordination, abuse, etc. by these physicians, and penalties that have been imposed against them (including deportation). It also recounts the regulations for the hospitals created by the East India Company.[98]

"*Following the passage of the Law establishing the General Medical Council in England in 1857, the British physicians working in India were registered with the GMC and were subject to its disciplinary supervision. As the number of qualified physicians in Indian medical schools grew, it became essential to establish legislation for them*."[99]

For criminal proceedings and for other reasons, Coroner's legislation applicable to Bombay and Calcutta was adopted by the Colonial Government in 1871.[100] It outlined the role of physicians in the process of autopsy and investigation. However, it required many more years to pass the legislation for the establishment of indigenous medical councils. In the meanwhile, legislation was established on the prevention of hazardous epidemic illness spread, the segregation and

[95] *Id.*
[96] *Id.*
[97] RANGARAJAN LN, KAUTILYA'S ARTHASHASTRA, New Delhi, Penguin Books, 1st ed. 130-131.
[98] *International comparison of ten regulatory medical systems*, available at https://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR691.pdf (last visited August 10th, 2021).
[99] *Id.*
[100] *Id.*

medical treatment of destitute, etc.[101] the pandemic was enacted for the first time in 1807 and is still in effect with the changes and in the early 1980s the Lepers Act 1898 was abrogated and replaced by legislation.[102] The Bombay Medical Act was enacted by the Grant Medical College Society in 1880 and the Medical Council was created. "*The proposed regulation comprised the appointment of a registrar, the keeping of the name in a record, and a punishment for wrongdoings. In 1912, the Bombay Presidency passed the Bombay Medical Act*."[103] Medical legislation quickly followed in several other provinces. The medical law in Bengal and Madras was adopted in 1914.[104]

The Indian Medical Degree Act, enacted by the Indian Legislative Council and ratified by the Governor General in 1916, soon followed this provincial legislation.[105]

After the Indian Medical Council Act 1933 was enacted, the Indian Medical Council, a national statutory entity for physicians of modern medicine, was established. The Indian medical systems had their first legal legitimacy and registration when the Bombay Medical Practioner Act was enacted in 1938.[106]

C. Modern Development in Laws

Independence in 1947 opened up a new era in developing organised health services that gave people greater rights. In addition, the State has also launched new laws, amended colonial laws and created case laws to consolidate people's rights in health care and extend their rights. The challenge facing the nation at the moment of independence and the first few years of its plans was to build physical and institutional infrastructure for the fast growth or modernisation of India. In due course, Parliament adopted several laws and acts to reinforce the provision of healthcare in India.[107]

"A *properly qualified medical professional, i's. the doctor, has the right, by registering itself with the medical council of the State in which he resides, to attempt to practise medicine, surgery or dentistry by following the process specified by the stat medical act. The stat medical*

[101] *Id.*
[102] *Healthcare system in india*, INTERNET STUDENT INSURNACE, available at: https://www.internationalstudentinsurance.com/india-student-insurance/healthcare-system-in-india.php (last visited on August 10th, 2021).
[103] *Id.*
[104] *Supra* Note 87, at 54.
[105] *Id.*
[106] *Supra* Note 88, at 54.
[107] M. Choksi, *Health systems in India*, 36(3) JOURNAL OF PERINATOLOGY, 9-12 (2016), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5144115/.

council is authorised to warn, refuse to register or delete the name of a doctor who has been judged by any court for any crime which cannot be rectified or determined to be guilty in any professional respect of notorious behaviour." The State Medical Council is also authorised to include the doctor's name on the registry.[108]

In Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation 2002, provision has been made on the offences and professional misconduct which may be taken before the relevant medical council (State/Medical Council of India). No action may be taken against a medical practitioner until he or she has had a chance to be heard in person or by a lawyer.[109]

D. Judicial Intervention

The Supreme Court made clear that the basic right to life includes the right to emergency health treatment within its limits. The most significant decision marking this significant occurrence is that of *Parmanand Katara V, Indian Union (Supreme Court 1989).*[110] In this instance, a scooter was denied admittance to the closest hospital on the pretext that the facility was not qualified to handle medical situations. In its judgement, the Supreme Court said that the duty of medical experts to give care in crises is beyond patients' right to reject their professional treatment. Under Article 21[111] (basic right of life), according to the right to emergency care, the Court clearly declared that 'Article 21 of the Constitution imposes on the State a duty to preserve life. Interestingly, the Supreme Court continued, that not only government hospitals, but every doctor has a professional responsibility to extend their care with the necessary competence for the safeguarding of life at a government hospital or otherwise.

In another case *(Paschim Banga Khet Majdoor Samity v. West Bengal, Supreme Court, 1996)*[112], people with headache following an accident by train were denied treatment in different hospitals on the pretext that they lacked sufficient treatment facilities and amenities. In this decision, the Supreme Court further expanded the right to treatment in an emergency and continued to affirm that a government hospital's refusal to give a person who is in need of such treatment with prompt medical care violates its right to life, as provided for in *Article 21.*[113]

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[108] *Id.*
[109] *Id.*
[110] *Parmanand Katara v, Indian Union,* 1989 SCR (3) 997.
[111] INDIA CONST. art. 21.
[112] Paschim Banga Khet Majdoor Samity v. state of West Bengal, 1996 SCC (4) 37.
[113] Supra Note 111, at 58.

E. Involvment of Criminal Liability

Criminal law attempts to shape individual conduct in a socially acceptable way. It seeks to apply to a large degree the principles of social mortality. Criminal law identifies and punishes specific kinds of human behaviour as offences. The remission of medical professionals in their responsibilities and obligations and their lapse may result in criminal liabilities, liabilities of a criminal court and punishment under the provisions of the law.[114]

The criminal law works on a doctor in a different way than regular people. This is because it enables a physician to injure the patient in order to avoid further damage. The key field of criminal law for a physician is life-related crimes. These crimes are primarily assassinations, injuries, serious hurts and abortions. A doctor may in general be prosecuted for any of these crimes. The criminal law, however, equips a physician with three strong defences: (1) informed approval, (2) necessity and (3) good faith.[115]

Other criminal responsibilities linked to several parts of the Indian Criminal Code, the Code of Procedure and various statutes, such as MTP, PCPNDT, human organ transplantation Act, etc.[116]

F. The United Kingdom

In the wake of the Second World War, the UK health system (NHS), was established and began operational on 5 July 1948. In 1942, the 1942 Beveridge Report on Social Insurance and Allied Services was first presented for the Parliament, and it is the legacy of Aneurin Bevan, a coal miner, who became a politician and later a health minister. "*It established the NHS on universality principles, free at the point of delivery, equality, and paid for by central financing. Despite many political and organisational changes, NHS remains a service which is generally accessible and which is supported by taxes and national insurance payments, and cares for individuals on the basis of their needs and not their capacity to pay*".[117]

The central government is responsible for health care and health policies for England, while the respective government is responsible for Scotland, Wales and Northern Ireland.[118] The healthcare system consists of two broad sections throughout all the United Kingdom: "*one on*

[114] Indian Penal Code, 1860.
[115] *Id.*
[116] SINGH J, MEDICAL NEGLIGENCE AND COMPENSATION, Bharat Law Publication, 3rd edition.
[117] Kate Diesfeld , *Introduction to Medical Law*, 27(3) JOURNAL OF MEDICAL ETHICS, available at https://jme.bmj.com/content/27/3/209.1 (last visited on August 10th, 2021).
[118] *Supra* Note 98, at 56.

strategy, policy and management, and one on actual medical/clinical care, which in turn is divided into primary healthcare (community health care, GPs, dentists, pharmacist, etc.) and secondary (hospital based); (specialist hospitals)".[119] There are increasing differences between the two major groups. Over the past decade in particular, and guided by the reports "Shifting the balance of power: the next steps" (2002) and "Wanless" (2004), the gradual change to the NHS has led to a major shift towards local rather than central decision-making, the removal of barriers between primary- and secondary care and greater emphasis on patient choice. The government of 2008 consolidated this approach in its "NHS Next Stage Review: High Quality Care for All" health plan (Darzi Review) and in 2010, it reiterates the government's current Health Strategy "Equity and Excellence: Liberating the NHS."[120]

The UK administration has recently unveiled plans for the biggest transformation in the NHS since it was founded. The current Conservative-Liberal Democrat coalition government stated in the 12th July 2010 White Paper on Equity and Excellence: Liberating the NHS a plan of how to "build a more responsive patient-centred NHS that delivers results which are among the finest in the world."[121]

Although many individuals are not typically associated with the realms of law and health, they interweave wonderfully in the United Kingdom. From your rights under the healthcare of the hospital medical team to public health and safety, there are laws that safeguard your health everywhere.[122]

i. The Law and Health

There are laws and charters across the UK to ensure that your health and rights are safeguarded in medical treatment. This legislation will guarantee that your privacy is maintained, that your permission is acquired before treatment and that medical personnel are not able to do operations without appropriate care. As a consequence, medical personnel in both the criminal and civil courts may be held accountable if they violate the law.

ii. Legal health and safety requirements

Although health and safety regulations may seem onerous, they do exist to make sure you are safe in a number of locations. Health and safety at work may protect you from harm; these

[119] *Supra* Note 117, at 59.
[120] Konstantina Grosios, *Overview of healthcare in the UK*, 1(4) EPMA, (2010) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405352/.
[121] *Id.*
[122] *Id.*

regulations can assist you to stay safe in the workplace from the asbestos free environment to fire exits. Similarly, health and safety in an academic setting helps youngsters always stay safe, such as having a supervisor of the playground. There are also health and safety in a range of public spaces. The objective of health and safety legislation is not to eliminate all hazards, but to minimise the most harmful ones out there, lawmakers and governing bodies.[123]

iii. Medical and ethical law

The way society perceives ethics impacts medical legislation and its implementation. As the moral ideals of society evolve, so does law. For example, the abortion legislation of 1967 was adopted when it was generally recognised that abortions are essential for the preservation of women's lives. Similar ethical shifts affect the way medical legislation is applied consistently. British culture constantly considers euthanasia issues for the courts, which was unheard of few decades before. As a consequence it is possible to work as a professional, researcher, policy maker or academic in medical law and ethics.[124]

iv. Business legal health checks

In the corporate sector, certain health checkups are legal. At the same time, legislation is also in place to guarantee that health controls are deliberately and freely carried out. In jobs where care for others, chemicals and hard lifting, occupational health inspections are necessary. These tests guarantee that you are fit for work before starting work. In the same way, certain jobs may need regular health checks; for example, if you work in a laboratory, chemical burns may be checked. There are rules in place throughout any application procedure to guarantee that you are not scrutinised too frequently. This guarantees that privacy is maintained while it remains secure.[125]

v. Medical Attorneys

In the United Kingdom, applicants and barristers are available for legal assistance on medical issues. These professions in England and Wales are members of the law society or of the English and Welsh bars. They are members of the Scottish Law Society in Scotland. The Northern Ireland Law Society controls these people in Northern Ireland. Each individual practising in medical law typically has a bachelor's degree, post-graduate certification and a

[123] *Id.*
[124] *Id.*
[125] *Id.*

two-year training under a competent person. Alternative paths to medical law are available, although they are longer than academic paths.[126]

vi. Law on Public Health

Public health legislation is in place to ensure a healthy and safe British country. There are legislation ranging from immunisation programmes for all residents to manufacturing and company rules reducing the amount of illnesses and accidents that people face on a regular basis. Public health legislation, for instance, establishes the cleanliness standards required from kitchens in restaurants; therefore, fewer individuals are facing potentially deadly illnesses than if the laws were not in existence. Social workers are also helped by public health legislation; for example, public health has a role to play in child nutrition. Social services may act if nutritional requirements are not fulfilled; however only in extreme instances, it is public health legislation that guarantees that children be properly fed. Infringements of public health legislation may lead to criminal and civil proceedings.[127]

The overall health and organisational and ideological difficulties confronting the UK health system are not unlike those encountered by a large number of national health systems worldwide. With the subsequent rise in chronic illnesses such as cancer and neurological disorders, life expectancy has gradually increased worldwide. A pandemic in obesity and related diseases such as diabetes and cardiovascular dismast has been produced by negative environments and livers. In the UK, coronary heart disease, cancer, kidney illness, adult mental health and diabetes account for about 16% of the total National Health Service (NHS) expense, 12% of the morbidity and 40 to 70% of the death rate. Health inequality is on the rise throughout Western countries with minority and ethnic groups suffering most from severe diseases, early mortality and disability. "*As the health of all groups in England improves, the Health Committee of the House of Commons warns that over the past 10 years, health inequalities between the social classes have widened – the gap between men has increased by 4 percent and women by 11 percent, as health of the rich is improving much faster than that of the poor. The emphasis and practise of healthcare is changed from providing treatment and palliative care historically to increasingly dealing with chronic illness management and rehabilitation regimens and to providing disease prevention and health promotion initiatives*".

[126] *Id.*
[127] *Id.*

Pay-for-performance, regulatory reforms and cost-effectiveness are becoming a major consideration for new clinical practise initiatives.[128]

Preventive medicine is well entrenched in the United Kingdom Healthcare System and more and more predictive and personalised methods. PPPM measures may be the answer but also the source of the health and health problems and dilemmas faced by health systems, such as the NHS. Effective PPPM implementation needs a scientific knowledge of illness and health, as well as technical progress, comprehensive plans, evidence-based health policies and proper regulation. It is also very important to educate healthcare professionals, patients and the public. However, there is little question that the proper use of PPPM may contribute to the NHS' goal for achieving health results that are among the best in the world.[129]

G. The United States of America

In the 20th century, the law was closely engaged in medical practise. Legal or forensic medicine has historically been a profession dedicated only to medicine in the courtroom in two environments: forensic pathology and forensic psychiatry. Traditionally, the pathologist has been required to identify and testify to the cause of death in instances of suspected murder and to the features of different injuries including crimes such as attack and violation. Medical evidence may also be necessary in civil disputes involving work injuries, careless injuries, car accidents and paternity lawsuits, for example. Likewise, when a defendant advocates insanity as a defence, a psychiatrist must examine the defendant and provide witness to the defendant's state of mind at the time of the offence. The important issue is generally whether the illegal behaviour of the defendant was the result of a mental disease or if he or her could discern between right and wrong. Especially civil proceedings, in instances involving child custody and involuntary commitment to mental illness, a psychiatrist often appears as a witness.[130]

The legal environment has evolved dramatically since the 1960s. For many doctors, civil proceedings claiming medical negligence have become a part of professional life. Issues formerly related to ethics such as abortion and ending medical treatment, as well as informed consent and patient rights have become significant civil rights problems in courtrooms across the globe. The legal system has been engaged in extensive campaigns aimed at stopping

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[128] *UK National Health Service law*, SOCIALIST HEALTH ASSOCIATION, available at https://www.sochealth.co.uk/national-health-service/health-law/ (last visited on August 10th, 2021).
[129] *Id.*
[130] CHARLES FOSTER, MEDICAL LAW – A VERY SHORT INTRODUCTION, oxford university press (2013), available at https://www.veryshortintroductions.com/view/10.1093/actrade/9780199660445.001.0001/actrade-9780199660445.

infectious disease transmission, such as acquired AIDS and influenza in the areas of privacy, secrecy, obligatory immunisation and research on human beings. Since the attacks on America in 2001 on 11 September, doctors have also been closely engaged in preparation for potential bioterrorist strikes using infectious pathogens such as smallpox.[131] These preparations include an unsuccessful effort to vaccinate all emergency medical professionals against smallpox and successful attempts to involve governmental and municipal public health organisations in emergency preparedness planning. These later preparations involve evaluations of the adequacy of public health legislation, which is mainly state legislation.[132]

The American legal philosopher, Lon Fuller, differentiated in the 1960s between "morality of aspiration" and "morality of obligation." The first may be referred to as ethics, the latter legislation. Ethics teaches individuals what to do and represents the goals to be achieved. Unethical conduct leads to penalties linked to how a person, by him or herself and others, is regarded. Law, on the other hand, establishes social limits for acts, which may only be exceeded by the danger of external penalties such as imprisonment or a loss of medical licence. This may explain why ethical standards are typically generalised, whereas laws are usually more precise.

H. Judicial Pronouncements

Advances in medicine, such as CPR and mechanical ventilators (which breathe for patients who are unable to use their lungs), have sometimes prevented deaths. In certain circumstances, it's difficult to reconcile ethical ideals with reality. If a young woman in a permanent coma is removed from her mechanical ventilator, she will die, but if the equipment is left in place, she may live for decades (in a coma). What the hippocratic goal of "no harm" requires is not clear.[133]

In 1976, the New Jersey Supreme Court addressed the identical concerns in ***Karen Ann Quinlan***.[134] She died peacefully after her parents requested physicians to remove the motorised fan. The doctors refused, citing medical ethics, believing it was unethical to take actions that might cause the patient's death.

The Quinlan family's lawyers argued in court that the issue was not medical ethics, but rather the patient's freedom to refuse an invasive treatment that did not work. According to the Court,

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[131] *Id.*
[132] *Id.*
[133] *Supra* Note 139, at 63.
[134] George J. Annas, *Health law*, BRITTANICA, available at https://www.britannica.com/science/health-law (last visited on August 10th, 2021).

patients have a legal right to refuse medical care, and Karen Ann Quinlan's parents may use that right on her behalf. A hospital ethics council may approve to withdraw the ventilator and all persons involved may be protected from civil or criminal liability if they agree with permanent coma prognosis. Karen Ann Quinlan's ventilator was turned off, yet she continued to breathe. Nearly ten years later, she died of pneumonia.

Karen Ann Quinlan's storey became a model for modern medicine and the intersection of medical ethics and law. Despite the physicians' and court's disagreements on medical ethics, the case centred on medical practise and the fear of legal liability. Modern physicians fear both criminal and civil actions charging murder or assisting suicide. To address these problems, the New Jersey Court created an ethics committee with legal immunity and responsibilities.[135]

Although North America, Europe, and Australia have established ethics committees to educate hospital staff on topics such as detention and withdrawal of treatment, other courts have not followed this approach. In fact, physicians are seldom charged with a crime for decisions made in patient care. For example, the Massachusetts Supreme Court defined criminal law as follows:

Regarding criminal liability, there is precedence that suggests the physician is protected if he acts in good faith and is not substantially unreasonable by medical standards.[136]

The *Quinlan rationale* has been expanded in the United States to include the freedom to refuse all medical treatments for all competent individuals, terminally sick or not (including artificial feedings). Many religious groups still oppose artificial feeding, and lobbied Congress in 2006 to keep the Terri Schiavo feeding tube in place. For example, whether a person is competent or incompetent, courts assess his or her wishes based on prior statements or, otherwise, the patient's best interests. Some people express their wishes for treatment in "living wills," describing their preferences for treatment in certain circumstances. Doctors may use the will to live to detect a patient's wishes that is unable to express himself. Because it is difficult to predict when individuals would die, Nancy Cruzan (a young lady in a similar situation to Karen Ann Quinlan but who required tube feeding to live) was referred to as a "proxy of health care" by U.S. Supreme Court Justice Sandra Day O'Connor. In this agreement, a person may delegate decision-making authority to another (such a close family member or friend) if they become incapacitated. This person has the same rights to refuse medical treatment as the individual.[137]

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[135] *Id.*
[136] *Id.*
[137] *Id.*

The American Medical Association stated denial of treatment is in line with medical practise and ethics. A few countries have gone farther and decided that physicians may legally and ethically help terminally ill people choose to die via lethal injection. In 1997, the US Supreme Court ruled unanimously that "*every patient had the right to refuse medical treatment. However, some countries may prohibit physicians from assisting in patient suicides due to the danger of dying, sick, or socially isolated patients. Law and medical ethics are comparable here*."[138]

Medicine is founded on ethics and law's fundamental concepts. Both legislation and medical ethics depend on the concepts of competent individuals making decisions, benefit (or at least non-malice) on the side of medical practitioners, and justice as a justice that medical practitioners and society offer all patients.[139]

I. Some restrictions under the US Laws

vii. Determination of death

The law supports customary medical practise in significant measure and allows physicians substantial freedom. A death certificate is a spectacular example. A doctor declares a person dead in almost every nation and gives a death certificate according to recognised medical standards. However, if complete brain death is an accepted definition of death in the medical world, there is significant discussion over whether physicians should maintain that authority (instead of the past definition of irreversible cessation of respiration and heartbeat).[140]

In someone whose functions would otherwise cease, a mechanical ventilator may artificially support breathing and circulation. The potential of organ donation was evident in the late 1960s and the seeming inefficiency in using limited medical resources to preserve the circulation became a matter of concern. Physicians suggested that the termination of irreversible brain activity should be used as death criteria. Since then, most western countries and Japan have taken up this definition either by allowing physicians to declare death, by enacting specific laws to support it, or by making court judgments validating such declarations. This will

[138] *Id.*
[139] *Id.*
[140] Madeline Moreira, *Determination of Death and the Dead Donor Rule: A Survey of the Current Law on Brain Death,* 41(3) J MED PHILOS, 237-256 (2016), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4889813/.

probably continue as long as physicians interpret death as either a constant breathing and circulation loss or a permanent stop of all brain activity.[141]

viii. Termination of pregnancy

Pregnancy termination is a contentious practise, but in many countries it is a privilege. Even in other controversial areas, doctors weigh widespread legal weight. In nations such as the United States, the doctor, rather than the state, determines whether a foetus is viable (i.e., capable of surviving independently of its mother). When the Supreme Court found that the Constitution protects abortion, it emphasised that a woman and her doctor should decide. In any event, the attending doctor must determine if a woman's life or health is at risk. The law may restrict treatments for mature minors and adults, such as abortion, sterilisation and even birth control, although it is up to the physician to decide. In 2007, the U.S. Supreme Court created a large exception when Congress classified a procedure as a "partial birth" abortion. (an operational abortion that removes a late-term foetus via the cervix). The Supreme Court decided 5-4 that Congress may prohibit this procedure if it concluded that it violated medical ethics and that there were alternatives that were less offensive to safeguard the lives and health of women seeking abortion.[142]

ix. Suicide

The authorities must be notified of unexpected deaths to ascertain whether murders, suicides or accidents were involved. An investigator must first make a preliminary finding before submitting the case to the police or prosecuting authorities, whether it an examiner, coroner or other title. "*In most western countries, this person is either a lawyer or a doctor. In the United States, a number of jurisdictions use an elected coroner (which may or may not be a medical practitioner).*" The coroners in London are physicians and attorneys. The primary evidence of the coroner is the autopsy report on the dead body.[143]

x. Public investigation

Physicians may be obliged to report to authorities certain patients or incidents. Certain communicable diseases must be reported to public health authorities. Child abuse and gunshot injuries should be reported (such as the child welfare authority or the police). Public reporting

[141] *Id*.

[142] Abortion laws in the US – 10 things you need to know, Amnesty International (11 June 2019), available at https://www.amnesty.org/en/latest/news/2019/06/abortion-laws-in-the-us-10-things-you-need-to-know/ (last visited on August 10th, 2021).

[143] Suicide, National Institute of mental health, available at https://www.nimh.nih.gov/health/statistics/suicide (last visited on August 10th, 2021).

tends to make the doctor a state agent rather than a patient, which is an uncomfortable duty. No wonder, private physicians report less publicly than hospital ERs.[144]

Doctors may need to protect some individuals from their patients under extreme situations. Therefore a psychologist had a "responsibility to protect," if the psychologist felt "or should have believed" a person who was threatening to be killing his patient, the risk was real. Because the psychologist failed to engage his patient willingly, the patient escaped from the doctor's care and murdered his former girlfriend.[145]

J. Medical Negligence

Patients who experience medical negligence may seek redress via the nation's legal system. In the USA, physicians are often prosecuted for negligent injury.[146]

Professional negligence is a failure to treat a patient with the care and skill that a prudent, competent person would use in the same or similar circumstances (such as a physician, dentist, nurse or pharmacist). It is not the practitioner's responsibility to guarantee a patient's outcome.[147]

A valid claim for infringement should contain four elements: duty, damages, and cause. "*The claimant must meet each of these requirements by a large margin (more likely than not to be true). The practitioner must have a relationship with the patient (requiring ordinary care), must have breached this duty (as determined by the appropriate degree of care), and must have caused physical or financial damage to the patient*".[148]

To establish the standard of care, physicians usually depend on expert testimony from other qualified doctors. Because a lay jury is unfamiliar with medical practise, such proof is needed. Experts may rely on criteria established by medical organisations such as the American College of Obstetricians and Gynecologists. These organisations certify physicians who have completed postgraduate coursework and practise standards. Specialty medical groups uphold the standards needed for specialist practise and provide patients with reasonable assurance. Failure to meet these standards by an expert is indication of fault, but not conclusive (the practitioner may have a valid excuse for not following custom, such as an emergency situation

[144] *Supra* Note 102, at 57.
[145] *Id.*
[146] B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467(2) CLIN ORTHOP RELAT RES, 339-347 (2009), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628513/ (last visited on August 10th, 2021).
[147] *Id.*
[148] *Id.*

or lack of equipment). Compliance with the criteria is evidence of appropriate treatment, but not definitive, since other factors may have rendered the physician's actions imprudent.[149]

To penalise a doctor who always follows the profession's care standard is not a malevolent act, but a complaint to the licencing or registration agency. Discipline by public licencing bodies is uncommon.[150]

Medical malpractice serves three functions: quality control, harm compensation, and emotional vindication. Quality control is probably best achieved when medical professionals set the standard of care and patients and jurors follow it. Serious injuries have a much lower compensation. Examples of emergency fees include 20%–40% of the entire amount awarded to the plaintiff in cases of negligence. Less severe injuries may have limited compensating remedies. Injury compensation is not a major issue in countries with public health insurance (since all medical bills are paid regardless of cause). However, non-economic damages, often described as "pain and suffering," frequently need litigation to recover. The full-service countries like Sweden and New Zealand have created "no fault" compensation schemes for all citizens. However, in the United States, where over 40 million people lack health insurance, a medically induced injury may turn into a financial catastrophe.[151]

Emotional vindication measures customers' ability to complain and receive a satisfactory response. Based on consumer concerns, Americans file medical claims ten times more often than Britons. For example, different legal systems and regulations, access to attorneys and courts, payment methods for medical services, the UK's National Health Service, and alternative grievances are all practical and cultural causes for the disparities.[152]

The growing safety movement is based on the Institute of Medicine's conclusion that over 100,000 people die each year in US hospitals. Most of these deaths are due to caregiver carelessness, which may be reduced by simple precautions including hand washing, using medical records, and properly identifying each patient.[153]

K. Comparison and Conclusion

Countries such as India have systems that are inclusive. Each state in India governs healthcare professionals. The Indian Medical Register is maintained and valid across India by a Medical

[149] *Id.*
[150] *Id.*
[151] *Id.*
[152] *Id.*
[153] *Id.*

Council. People are also included in these registers in the Indian Medical Register. Those holding a university degree, usually an M.B., B.S. or an L.M.P., are registered for these registers. There are also several foreign qualifications recognised.

On the other side in Britain, where there is no government medical monopoly, one of the most merciful systems is. The protected condition is that of a physician. The Medical Act of 1978 permits registration of anybody who has completed the necessary education and exams. The issuance of medical certificates and appointments in public hospitals is all the exclusive responsibility of registered physicians. It's a felony to imply that you are registered, but not involved in healing. They may be private practitioners.

Moreover the American system is based on patients' rights as the law is more inclined towards the consumer or the patient for them to understand that their life holds a stake in the medical services provided by them hence they have the doctrine of informed consent which lacks in UK's medical health system.

Every country has its uniqueness but the most important part while making medical laws is rights and interest of the parties involved. Hence at last it is right to say that India is yet to plan a long journey to cope up with the medical laws defined in these countries as we do not have such medical advancement as their country.

CHAPTER 5: JUDICIAL REDRESSING TOWARDS MEDICAL NEGLIGENCE

I. TABLE OF CONTENTS

The medical profession, albeit one of the noblest, is not immune to carelessness due to a lack of appropriate care and skill or deliberate neglect, resulting in patient injury or death. In India, there are no specific guidelines for dealing with medical malpractice. As a result, the various courts and law enforcement agencies' interpretations of the law and circumstantial evidence in negligence cases can be deceiving and lead to false convictions and punishments. Medical negligence has now become one of India's most critical problems.

II. INTRODUCTION

"*According to Winfield, negligence is defined as the breach of a legal duty to take care of a person suffering from illness and results in damage undesired by the defendant to the plaintiff. A violation of this duty gives a patient the right to initiate action against negligence*".[154] In ***Donoghue v. Stevenson***,[155] the notion of negligence and negligence law arose. Until this typical case, the opinion was that several interactions established a specific obligation like those of a doctor and a patient, an employer and an employee. With reference to another well-known English case, ***King v. Phillips***[156] it was noted that a matter of negligence arises only when the misconduct directly harms the complainant, and the damage should be foreseeable. Briefly, therefore, we might argue that harm is a crucial factor in negligence.

To enhance criminal law responsibility, the degree of negligence must be larger than the degree of negligence required to expand civil law accountability. When the charge in a criminal court involves criminal negligence, the basic issue of mens rea cannot be ignored. Lord Diplock spoke in ***R. v. Lawrence*** at a Bench of 5, and the other Law Lords agreed. He restated his opinion in ***R. v. Caldwell*** and addressed the issue of recklessness as a mens rea in criminal law. His lordship was not able to follow a simplistic method by classifying the test of responsibility as being "subjective" or "objective" to deal with any problems of criminal liability and said "the recklessness of the perpetrator presupposes something in the situation that would have drawn the attention of an ordinarily prudent person to the possibility of doing an act. It is only when the actor acts carelessly if, before performing the act, he either does not consider the possibility of risk or, after having realised that such a risk existed, he does it."

[154] GARNER A. B., BLACK LAW DICTIONARY. 10 ed. United States of America: Thomson Reuters; 2014. p. 1195-98.
[155] Donoghue v. Stevenson, [1932] UKHL 100.
[156] King v. Phillips, [1953] 1 QB 429.

The medical profession is considered to be honourable because it helps to save a life. We think life is God's gift. In consequence, a doctor plays a role in the plan of God because he is responsible for fulfilling his task. A patient usually looks for a doctor or a reputation-based facility. "*A patient's expectations are twofold: doctors and hospitals are expected to give medical treatment using all of their knowledge and ability, and they are also required not to hurt the patient in any way due to negligence, carelessness, or reckless behaviour on the part of their staff*."[157] Although a doctor may not always preserve a patient's life, he is required to use his unique knowledge and skills in the best way possible while taking the best interests of the patient into account. As a result, a doctor is expected to perform essential research or to seek a patient report. In addition, he asks the patient for informed consent before any serious treatment, surgery or intrusive inquiry is started unless there is an emergency. "*Failure of a doctor and a hospital to fulfil this commitment is fundamentally a tortious liability.*"[158] "*The right of a patient to get medical attention from doctors and hospitals is thus essentially a civil right. Because of informed permission, payment of a fee, and performance of surgery/providing treatment, among other things, the relationship takes on the shape of a contract to some extent, while key tort features remain. The Indian law protects doctors from criminal liability through sections 88 to 92 of the Indian Penal Code (IPC) because the law presumes that a doctor always acts in good faith for his patient's well-being.*"[159]

There has been an increasing awareness of patient rights in Indian society in recent years. This trend is exemplified by the current rise in medical or establishment liability measures that require reparation in medical malpractice cases, vitiated consent and the violation of confidentiality arising from the doctor-patient interaction. "*The patient-oriented approach to preserving human rights must be seen in the light of the arduous efforts of the Indian Supreme Court to make the right to health a fundamental right constitutional and the rapid reduction of government spending and substantial private investment in the health system. Current principles of the common law relating to carelessness, vitiated consent and infringement are taken into consideration in the medical professional responsibility adjudication process, whether in a consumer forum or the normal civil or criminal court*". We must also remember that preserving patients' rights should not be at the expense of professional integrity and

[157] REDDY KSN, 'THE ESSENTIALS OF FORENSIC MEDICINE AND TOXICOLOGY,' 34 ed. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.; 2014. p. 34-35.
[158] Charles worth & Percy, *Negligence*, (Christopher Walton, 14th ed., 2019).
[159] Indian Penal Code, 1860, § 88-92.

autonomy. There is no doubt that a good balance is needed. If not, the repercussions would be inexplicable.

III. UNDERSTANDING THE CONCEPT OF 'DUTY OF CARE, 'DEGREE OF CARE AND 'STANDARD OF CARE'

Negligence is not culpable and is not a legal liability in and of itself except when the law imposes a duty of care. Civil law is the most prevalent cause of action for carelessness. When there is a legal obligation to avoid doing something on intent, there is often a legal obligation to avoid doing it accidentally. A duty of care is a legal responsibility under Civil Law for an individual to exercise reasonable care in performing an act that may hurt others.[160] To file a negligence claim, a legal duty of care must be imposed. The law has placed responsibility for the treatment of patients in medical practice with doctors. A doctor's obligations to his patients are firmly defined. They include the duty of care to choose whether or not to take on the case, decide which therapy to offer and administer the treatment.[161]

A violation of any of these obligations gives the patient the right to sue for negligence. This care task starts when a patient enters a hospital, and the doctor visits the patient, irrespective of whether or not informed consent was granted.[162] It is the doctor's job not only to treat the disease but also to take necessary precautions to ensure that patients do not suffer as a result of the side effects of the treatment scheme. As such, the role of the doctor is to do all investigations, to interpret the results, to diagnose the illness properly, to treat the disease, and to monitor the patient until he has been completely cured.[163] All of the tasks outlined above, including the referral obligation, are primarily the treating physician's responsibility.

This attention does not include professional opinions on findings, radiological examinations, biochemistry reports, chemical toxicity analysis or consulting. A laboratory has no duty to treat a patient despite the fact that it analyses body fluids and makes recommendations for treatment.[164] The task of the treating doctor is to analyse positive and negative findings, genuine or false discoveries, connect them to the clinical picture and offer the best available treatment. Similarly, a suggestion from another doctor will be treated as laboratory results.

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[160] Mathiharan K, Patnaik AK, '*Medical Negligence and Consumer Protection Act*,' 23, MODI'S MEDICAL JURISPRUDENCE AND TOXICOLOGY, 149-200, 2005.
[161] Mudur G., '*Indian Supreme Court ruling makes the arrest of doctors harder*, BMJ, 331(7514) 422, 2005.
[162] FITZGERALD PJ, SALMOND ON JURISPRUDENCE, 14th Ed. London; Sweet & Maxwell: 1966.
[163] DENNING LORD MR, THE DISCIPLINE OF LAW, New Delhi; Aditya Books Private Limited, 1993.
[164] GUPTA RL, CONSENT TO TREATMENT. IN: THE MEDICO-LEGAL ASPECTS OF SURGERY, 16-30, 1st Ed. New Delhi; Jaypee Brothers: 1999.

The law does not require a standard of care that would make them guilty of neglect. On the other hand, individuals considered professional in society must maintain a higher level of care than those not. It is up to the law to define the line as clearly as possible so that it prohibits outrageous carelessness while yet requiring reasonable care. The standard of care in civil law refers to the degree of caution and judgement demanded by someone else.[165] For a successful negligence suit, a breach of the standard is required. In numerous professions, the standard of care is defined by the standard used by a fairly cautious professional in this sector. One way to determine whether a doctor is accountable for medical negligence is the Bolam test. The reasonable person test is a legal fiction from the beginning of the common law. An intelligent and rational person is supposed to symbolise a regular citizen. In making legal choices, the ability of this person to understand matters is evaluated. In areas such as negligence, the 'how would a reasonable person answer under these circumstances' plays a crucial role in legal reasoning. The law thus stipulates an obligation to provide for the care, but medical judgement determines the threshold.[166]

Carelessness can take various forms. It varies in this respect from other mens rea kinds. The intention is either present or absent; there is no way to know how much of it is present. The degree of carelessness, however, is commensurate with the risk to which the conduct exposes others. A person is careless if he or she puts others at risk of ill without intending, and the higher the threat, the greater is the carelessness. The risk is proportionate to the magnitude and probability of the impending evil.[167] The larger the terrible and the closer it is, the greater the disregard for the defendant. "*As carelessness varies in seriousness, it is necessary to grasp the level of care needed for guilty negligence and the level of care the law demands. The law does not mandate the maximum care that human nature is able to take, but rather the reasonable level of care given the size of the risk*". As a result, the law permits every man to expose his activities to a certain degree of danger while fully aware of the consequences.[168]

The higher the hazard, the more likely the defendant is to fail to take safeguards. There are numerous levels of negligence that can be taken into account by law, both for civil and criminal

[165] Kumar L, Bastia B.K., *Medical negligence- Meaning and Scope in India*, 51(181) J NEPAL MED ASSOC, 49-52, 2005.

[166] Samanta A, Samanta J, *Legal standard of care: a shift from the traditional Bolam test*, 3(5) CLIN MED, 443, 2003.

[167] Nancy E. Epstein, *Legal and evidenced-based definitions of standard of care: Implications for code of ethics of professional medical societies*, 9 SURG NEUROL INT, 255, 2018.

[168] Foster C. Bolam: consolidation and clarification. Health Care Risk Report.1998, 4(5), 5.

purposes. When it comes to offences of carelessness, the law may state that the more neglect, the harder the sentence. Ordinary negligence is defined as a failure to use reasonable care that would not but might subject a person to legal liability. Criminal negligence is a more significant defect and a violation of the standard of care that criminally blames a person. If newborn children are left to die due to a lack of medical care or nursing, it is possible that their death was caused by only negligence, but it is more likely that they were caused by malice. Gross negligence is a higher breach of the standard and a fully unjustifiable failure to take care that makes the defendant accountable not only for the offence but also for culpable homicide if his actions result in the death of another person.

IV. TREATMENT WITHOUT INFORMED CONSENT MAY ALSO AMOUNT TO NEGLIGENCE.

"*The presence of a doctor-patient relationship is a criterion for the doctor to be accountable. The relationship is fiduciary in nature, and the obligation of the physician is stepped up when the patient has a foggy understanding of the disease, diagnostics, therapy and all its effects*." On the other hand, the obligation to act in the patient's best interest cannot be extended to the point where acts are carried out against or without the patient's consent when the patient is able to understand them. Every patient has the freedom to self-determination and to refuse treatment, even if doing so would be irrational by most rational criteria, and the medical practitioner cannot impose his will on them. Suppose the original consent is not accessible for a number of reasons, such as the minor, mentally ill or unconscious patient. In that case, the replacement/substitute consent can be used by medical practitioners.

In the matter of ***Samira Kohli v. Dr Prabha Manchanda***,[169] a 44-year-old female with a menstrual flow for nine days was taken for ultrasound and was advised to undergo general anaesthesia laparoscopy to confirm her diagnosis. The patient was evaluated laparoscopically during general anaesthesia, with the simultaneous agreement of the mother for "*abdominal hysterectomy (removal of the uterus) and bilateral salpingo-oophorectomy (removal of ovaries and fallopian tubes)*" the Supreme Court ruled that consent given for a diagnostic procedure/surgery is not valid for performing conservative or drastic therapeutic surgery, unless in life-threatening or immediate cases. The patient's permission to a certain operation was also not construed as authorization for an additional unauthorised operation requiring removal of an organ because it would be advantageous for the patient or could prevent some future hazard if the life or health of the patient is not in urgent danger. In its judgement, the

[169] Samira Kohli v. Dr Prabha Manchanda, 1(2008) CPJ 56 (SC).

Supreme Court considered the ideas of "real consent" in the UK and "informed consent" in the USA, considered and clearly rejected US criteria that were too high and unfit for Indian conditions.[170] It was also held that a doctor must obtain the patient's consent, which must be "real and valid," that the patient must be given "adequate information" to enable him or her to make an informed decision, that remote possibilities need not be disclosed, and that the nature and extent of the information to be given will be what is considered "normal and proper by a body of medical men." Following that, "*in **Malay Kumar Ganguly v. Sukumar Mukherjee**,[171] the Supreme Court, without referring to its previous judicial opinion in Samira Kohli, emphasised the importance of doctors engaging with patients during treatment, particularly when the line of treatment is contested, has serious side effects, and alternative treatments are available, and observed that in the future, litigation may be based on the theory of lack of informed consent."*

V. MEDICAL NEGLIGENCE LAWS IN INDIA: PEAK IN THE LEGAL REGIME

The Indian Penal Code establishes a unique legal status for medical practitioners than regular individuals. According to Section 304A of IPC, "whoever causes the death of a person by a rash or negligent act not amounting to culpable homicide shall be punished with imprisonment for a term of two years, or with a fine or with both." [172] Therefore, in certain cases, for instance, when a patient dies when the doctor manages anaesthetics during surgery, the doctor may be held criminally accountable. Death must also be caused by malicious intentions or excessive disregard. 10. Despite patients' rights, there are some exceptions in the form of sections 80 and 88 of the Indian Penal Code allowing defences for physicians. 'Nothing constitutes a crime that is committed in a legitimate manner, by lawful means, and with adequate attention and caution, by accident or misfortune without any criminal intention or knowledge' as per section 80. 'If a person acts in good faith in the interests of another person or does not intend to cause harm even though a risk exists, and the patient has given explicit or implicit consent, it does not constitute a crime, pursuant to Section 88. It was stated in ***Kurban Hussein Mohammedali v. the State of Maharastra***[173] that "in order to impose criminal guilt under section 304-A, death

[170] Farrell AM. Brazier M, *Not so new directions in the law of consent? Examining Montgomery v Lanarkshire Health Board, 42* J MED ETHICS, 85-88, 2016.
[171] Malay Kumar Ganguly v. Sukumar Mukherjee, AIR 2010 SC 1162.
[172] Indian Penal code, 1850, §304A.
[173] Kurban Hussein Mohammedali v. the State of Maharastra, 1965 AIR 1616, 1965 SCR (2) 622.

has to be the direct result of the guilty and negligent act of the accused without the assistance of other persons."

The civil law topic that addresses negligence is significant since it covers so many issues. Even if doctors offer free services, this principle is valid in accordance with wrong or civil law.[174] "*You can claim that when the Consumer Protection Act stops, tort law begins. If the services supplied by doctors and hospitals do not fit under the scope of the CPA, patients can utilise the tort law to claim compensation. The burden of proof is on the patient to demonstrate that the damage was caused by the carelessness of the doctor or the facility*." In ***State of Haryana v. Smt. Santra***[175], the Supreme Court ruled that "every doctor is obliged to act with a fair degree of care and skill." But, as no person is the perfect person and even the most known specialist is able to make an error in diagnosing an illness, a doctor can only be held accountable for failing if he or she shows that no doctor with ordinary competence would fail to act with reasonable care. In ***Kanhaiya Kumar v. Park Medicare & Research Center***[176], the court clarified that negligence has to be proved instead of not presumed.

Medical negligence is the subject of debate in consumer laws. In 1990, there has been much debate and controversy about whether the terms 'services' in accordance with section 2(1) of the Consumer Protection Act encompass medical services explicitly or categorically. Any flaw, imperfection, deficiency or lack of quality, nature, or manner of performance which is required to be maintained by or under current legislation or which a person in accordance with a contract or in otherwise is undertaken to perform in respect of any service is referred to as a service deficiency. The issue is whether a complaint could be lodged, and the response is that a complaint could be lodged at the following places: "*District Forum where the value of the services and compensation requested is less than 20 lakh rupees or State Commission, where the value of goods or services and the compensation claimed is not greater than one crore rupees or the National Commission where the value of goods or services is greater than one crore rupees*"; The good news is that it only costs a few bucks to complain to the District Consumer Relief Forums. The 1995 judgement of the Supreme Court in the ***Indian Medical Association v. V.P. Shanta and Ors.***[177] put medical treatments under the concept of 'service.' This has developed a relationship between consumers and medical professionals in 'procedural

[174] Smreeti Prakash, '*A Comparative Analysis of various Indian legal system regarding medical negligence.*' INTERNATIONAL JOURNAL OF LAW MANAGEMENT & HUMANITIES, 2020.
[175] *State of Haryana v. Smt Santra*, (2005) 5 SCC 182, AIR 2000 SC 1888
[176] Kanhaiya Kumar v. Park Medicare & Research Center, III (1999) CPJ 9 (NC).
[177] Indian Medical Association v. V.P. Shanta and Ors, 1996 AIR 550, 1995 SCC (6) 651.

free' consumer protection by allowing contracting patients to sue doctors if they are injured during their treatment.

VI. A BRIEF REVIEW OF APEX COURT DECISIONS

Significant similarities were seen in some Hon'ble Supreme Court judgements; however, many contradictory judgments were handed down by other high courts and other civil courts, which caused confusion among medical experts and law enforcement bodies. Most rulings of the Supreme Court favour torts in medical negligence instances, with only extreme rashness and recklessness being tried in accordance with Article 304A I.P.C. and in no event in accordance with 304 I.P.C. In recent decisions, however, some high courts and tribunals went beyond the ambit of even section 304A of the IPC, applying section 304 of the IPC instead. There are certain odd cases registered in accordance with section 302 I.P.C.

A significant ruling of the Supreme Court concerning ***Jacob Mathew vs. the State of Punjab***[178] showed medical malpractice. Failure to do everything a judicious and reasonable man could do or would do anything that a prudent and sensible man could not do, based on the rules that generally govern the conduct of human affairs, is a violation of his responsibility. Neglect requires a special approach to therapy in the setting of the medical profession. Additional issues apply when a professional, especially a doctor, is rash or negligent. A case of workplace negligence differs from one involving professional negligence.

"*A basic lack of attention, a slip of judgement or an accident are not proof of medical care failure. A doctor is not liable for negligence just because there was a better alternative path or method of treatment or because a more qualified doctor would not have chosen to follow or resort to the accused's practice*." In the absence of measures, it is questionable whether these precautions were adopted that ordinary men considered being sufficient; the absence of exceptional or extraordinary precautions that would have prevented the specific event is not useful in assessing claimed carelessness. Similarly, in terms of information available at the time of the occurrence, not at the time of the trial, the standard of care is considered when the practice is evaluated as applicable. Likewise, if the allegations of negligence are founded on a failure to utilise particular devices, the charge shall be rejected if the equipment was not available in large part at the time it was advised (that is to say, at the time of the occurrence). A professional can be held responsible for negligence on the basis of one of two conclusions:

[178] Jacob Mathew vs. the State of Punjab, (2005) CASE NO: Appeal (crl.) 144-145 of 2004- Supreme Court of India.

either he lacked the requisite skills he claimed to have, or in particular circumstances, he did not exercise the talents he has with reasonable competence. The criterion for deciding whether or not the accused person was careless was that of a normal competent person with typical expertise in that profession. No person may claim to have the highest level of experience or skills in the field in which he or she works. Although a highly trained professional might have higher qualities, this cannot be utilised as the basis or measurement standard for the work of a neglectful professional.

In India, the test for medical negligence in the case of Bolam is still relevant.[179] The idea of negligence is defined differently in civil and criminal law. In criminal law, "*what may constitute negligence in civil law is not always negligence in criminal law. The element of mens rea must be shown to deem negligence an offence*". The degree of negligence, i.e., gross or extremely high, must be much higher if an act is regarded as criminal negligence. Failure that is neither gross nor higher may result in civil action but cannot be used to prosecute. Although the term "gross" in section 304A of the IPC is not used, it is generally known that in criminal law, negligence or carelessness has to be judged to be so high as "gross." As used in Section 304A of the IPC, the phrase 'crash or negligent act' shall be interpreted as 'grossly.' In order to prosecute a medical practitioner for negligence under criminal law, the accused must be shown to have or failed in the given facts and circumstances to do something that no medical practitioner in common sense or prudence would have done. The danger of the accused doctor should have been such that the damage which followed was most likely imminent. Res ipsa loquitur (i.e., the object itself talks) is a rule of evidence that applies to civil law, especially in cases of tort, and which helps to judge the evidence in negligence proceedings. It cannot be utilised in the area of criminal law to determine the responsibility for negligence on its own. If anything, res ipsa loquitur has a limited application in a trial of criminal negligence. 8

Consider another major case, ***Martin F. D' Souza vs. Mohd. Ishfaq***.[180] In 2009, it was decided in this case that "*whenever a Consumer Forum (whether District, State, or National) or a Criminal Court receives a complaint against a doctor or hospital, the Consumer Forum or Criminal Court should refer the matter to a competent doctor or committee of doctors, special committee, before issuing notice to the doctor or hospital against whom the complaint was made*." This is essential in order to avoid harassing doctors who ultimately do not find themselves irresponsible. The court further encouraged police officers not to arrest or harass

[179] Bolam v. Friern Hospital Management Committee, [1957] W.L.R. 582, 586.
[180] Martin F. D' Souza vs. Mohd. Ishfaq, (2009) CIVIL APPEAL NO. 3541 OF 2002- Supreme Court of India.

physicians unless the circumstances clearly fit within the boundaries laid down in the case of Jacob Mathew, or they themselves risk being prosecuted.

Moreover, in ***Dr S.K. Jhunjhunwala vs. Ms Dhanwanti Kumar***,[181] the court found that there must be a direct link between the two components to suit a doctor for negligence. One thing is that a patient gets unwell after surgery. It could be for a number of reasons. Another concern is Suffering from such a condition as a result of poor surgery, especially when the degree of neglect on the part of the doctor is high. In order to determine if a doctor is careless, medical evidence from experts in the field is needed. It is not enough to just show the former.

Furthermore, the National Consumer Dispute Resolution Commission ruled on the question of medical negligence in ***Superintendent, Royapettah vs R. Lakshmi***.[182] The Court disagreed with the notion that the patient was no customer because the surgery was a government hospital. The Supreme Court concluded in the cases of VP Shanta[183] and Savita Garg[184] that government hospitals were also responsible for medical negligence. On 1 July 2015, the Honorable Supreme Court found in ***V. Krishnakumar Vs. State of Tamil Nadu & Ors***.[185] that the Government of Tamil Nadu is liable for medical misconduct in a government hospital. The Supreme Court judgement in ***V.P. Samtha Vs Ima[186]*** states that government hospitals don't provide all patients with free care; hence even if patients are treated for free, they are not considered free.

VII. INTERPRETATIONS OF HON'BLE APEX COURTS WHO FAVOURS THE APPLICABILITY OF EVEN 304 A I.P.C. IN MEDICAL NEGLIGENCE CASES IN EXTREME RASHNESS.

Where criminal negligence is the charge in a criminal court, the critical component of mens rea cannot be overlooked. The moral responsibility for irresponsibility does not depend on a desire to harm others. It may be located near the sensitive state of mind and the present state of mind when an injury is intended. Optimization of offences may be motivated by a desire for excitement. For the purpose of criminal liability, the provisions of the Indian Penal Code of 1860 ("IPC"), which are generic in nature and do not specifically provide for medical

[181] Dr S.K. Jhunjhunwala v. Ms Dhanwanti Kumar, (2018) CIVIL APPEAL No.3971 OF 2011- Supreme Court of India.
[182] Superintendent, Royapettah v. R. Lakshmi, (2015) APPEAL NO. 210 OF 2015 - National Consumer Dispute Redressal Commission of India.
[183] Indian medical association v. VP Shantha,1(1996) CLT 81 (SC).
[184] Savita Garg v. Director, National heart institute, Case IV (2004) CPJ 40(SC).
[185] V. Krishnakumar Vs. State of Tamil Nadu & Ors, Civil Appeal No. 8065 of 2009.
[186] Indian medical association v. VP Shantha, 1996 AIR 550, 1995 SCC (6) 651.

negligence, are often employed. Because the reputation of a person is on the line, no rational professional would voluntarily commit an act or omission leading to a loss or injury of the patient. "*A frightened doctor, afraid of legal consequences, cannot perform a proper operation, and a shaky doctor cannot deliver the final dose of medication to his patient. Negligence is a breach of duty caused by the failure to do something that a prudent and reasonable person would do or by doing something that a prudent and reasonable person would not do*".

There are three basic elements of negligence: 'obligation,' 'breach,' and 'resulting damage.' In the context of the medical profession, negligence necessitates a unique approach to therapy. A simple lack of care, a lapse in judgement, or an accident are not evidence of professional medical negligence.[187] "*He cannot be held accountable for negligence simply because a better alternative course or technique of treatment was available or simply because a more skilled doctor would not have decided to follow or resort to the accused's practice or procedure*." When a profession embraces a variety of viewpoints on what constitutes an acceptable standard of conduct, the defendant's competence is measured against the lowest standard that would be considered acceptable.

Failure to take unique or extraordinary precautions that could have prevented a certain occurrence cannot be used as a yardstick for determining alleged carelessness. While evaluating the practice as applied, the standard of care is considered in light of knowledge known at the time of the incident, not at the time of the trial. Similarly, "*if the allegation of negligence is based on the failure to utilise certain equipment, the charge will be dismissed if the equipment was not widely available at the time (that is, at the time of the incident) when it was recommended should have been used.*" A professional may be held accountable for negligence based on one of the two conclusions.: -

"*1. Either he was not possessed of the requisite skill which he professed to have possessed, or,*

2. 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*

[187] Juhi Yadav., Mukesh Yadav and Sharad Chand, *Medical Negligence and Its Determinants*, INT J RECENT SCI RES, (2020).

is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices".

VIII. JUDICIAL DECISIONS IN REGARD TO VICARIOUS LIABILITY IN MEDICAL NEGLIGENCE

A hospital may be held responsible for a variety of reasons on many occasions. Several High Court rulings concluded that hospitals have been vicariously liable for patient damages resulting from the negligence of their workers. In ***Joseph v. Dr George Moonjerly***[188], the High Court of Kerala stated: "Persons who administer hospitals have the same duties as the humblest doctor; when they accept a patient to be treated, they must take proper care and skills to alleviate the patient.' Of course, the hospital administration cannot do it alone; they lack the ears to listen to the stethoscope and the hands to handle the surgeon's knife. The employees they recruit have to do so, and if they are irresponsible to treat, they are just as guilty as anyone who recruits people to do his job for him.

Another Madras High Court judgement, ***Aparna Dutta v. Apollo Hospitals Enterprises Ltd***[189]Concluded that the hospital was the provider of medical services. The rules according to which the hospital hires physicians and surgeons are between them, however in the case of third-party patients, the hospital cannot be excluded from being held accountable. The hospital should give such a medical-services and, if the service is deficient or the procedure is conducted carelessly, the hospital should be held responsible, and it cannot escape culpability by claiming that there is no master-servant relationship between the hospital and the survivor. The hospital shall be responsible for proved negligence, and the fact that the surgeon is no longer a servant of the hospital, etc., is not a defence.

In another case, ***Smt. Rekha Gupta v. Bombay Hospital Trust & Anr.***[190], the National Consumer Redressal Commission held that the hospital that employed all of them, regardless of the guidelines, was responsible for their actions. It cannot avoid culpability by claiming that it just provided infrastructure, nursing staff, support staff, and technicians and that it could not execute or recommend any operation or amputation on its own. "*The hospital raises any charge, including consultant doctor's consultation fees, on the patient and deducts a 20% commission when remitting funds to the consultant. Regardless of the outcome of the litigation, the hospital cannot absolve itself of responsibility on these flimsy grounds*".

[188] Joseph v. Dr George Moonjerly, 1994 (1) KLJ 782 (Ker. HC).
[189] Aparna Dutta v. Apollo Hospitals Enterprises Ltd, 2002 ACJ 954 (Mad. HC).
[190] Smt. Rekha Gupta v. Bombay Hospital Trust & Anr, 2003 (2) CPJ 160 (NCDRC).

In addition to their own personnel and other staff, physicians and other professionals, the hospital administration accounts for "*anaesthetics and surgeons, who practise independently but admit/operate a case. It doesn't matter if they are permanent or temporary, resident or visiting consultants in full or part-time*". The administration of the hospital is usually held responsible for any carelessness on the part of such staff. When a consultant surgeon who is not employed by the hospital performs an operation in the hospital and carelessness occurs, it has been determined that the hospital was providing medical services.[191] The circumstances under which the defendant hospital hires doctors and surgeons are between them, but this does not exclude the hospital from being held accountable in the case of third-party patients. Patients go to the hospital for admission, relying on the hospital for medical treatment at their expense. The hospital is expected to provide such medical services and, in the event of a deficiency in the service or in cases such as those in cases in which the operation was conducted "*carelessly and without caution, the hospital must be held liable, and it cannot be excused from liability due to the lack of a master-servant relationship between the hospital and the patient*".

Often, a senior or super-specialist carries out surgery in a centre where the expertise is not locally available. After surgery, a competent local doctor is tasked with postoperative care. The failure of the senior/super-specialist to follow postoperative therapy personally may not be regarded reckless if the postoperative care doctor is competent; this can also be stated of a visiting doctor.

The NCDRC has the responsibility for providing postoperative therapy and care to the patients in the hospital if the procedure is conducted in a hospital. Foreign doctors often do surgeries in India, and it is impossible to assure that a foreign doctor who may be no longer in the country provides postoperative care and therapy. However, "*if the visiting surgeon never asks about the condition of the patient and leaves the patient's postoperative and follow-up treatment in the hands of another doctor, who is unable to treat the patient appropriately, the patient can die*." In various incidents of negligence against state hospitals, the State was found to be responsible for the recklessness of its doctors or employees or particularly to be responsible when there is insufficient equipment or staff. In a couple of situations, the court issued decisions to recover compensation from state doctors whose carelessness was proven. In

[191] Frank A., *Experiencing illness through storytelling*, In Toombs SK, editor, HANDBOOK OF PHENOMENOLOGY AND MEDICINE, Springer; (2001).

Achutrao & Ors v. State of Maharashtra & Ors,[192] the Honourable Supreme Court held that "*while administering a hospital is a welfare activity done by the government, it is not an exclusive duty or activity of the government such that it may be regarded as exercising sovereign power*". As a result, the State would be held vicariously accountable for any losses incurred as a result of the carelessness of its doctors or other personnel.

In other instances, ***Smt. Santra v. State of Haryana & Ors***[193], the opinion that the State is not subjected to the disregard of its officials in conducting the sterilisation operation was not accepted in the light of the prior Supreme Court of India's ruling.

With the ***Rajmal v State of Rajasthan***[194], where the patient died of neurogenic shock following a laparoscopic tubal binding at a primary health centre, a Committee of Inquiry appointed by the Supreme Court found that the physician was not careless in the course of the procedure and that there were no questions about its competence, integrity and efforts. The death was linked to a lack of effective resuscitation and skilled staff, and the State Government was held to be responsible vicariously and ordered to pay the husband of the deceased.

In another case, ***Dr M. K. Gourikutty & etc. v. M. K. Madhavan and Ors.***[195], where a patient died as a result of post-partum sterilisation, the Court found negligence on the part of the defendants and held the State Government, anesthesiologists, and other staff vicariously liable rather than the State alone.

In ***State of Punjab v. Surinder Kaur***[196] Punjab and Haryana High Court found that a doctor working in a state hospital fulfils his duties while he or she works in the State, and, in such situations, the master is always responsible for his or her vicarious responsibility on the actions done by the employee during his or her work. It is the state's responsibility to judge whether erring doctors are responsible or not. It is their own affair; however, it is possible for the patient to recover the monies from the government of the state. The State authorities are responsible for ensuring that their personnel are available in the hospital on time. If a doctor or expert for any reason is unavailable, the hospital authorities should have been told in advance and other staff despatched. The main task of the hospital authorities is to ensure that the hospital or its officers are not irresponsible. The failure to provide a doctor, anaesthetist or assistant is

[192] Achutrao & Ors v. State of Maharashtra & Ors, JT 1996(2) SC 664.
[193] Smt. Santra v. State of Haryana & Ors, (2005) 5 SCC 182.
[194] Rajmal v State of Rajasthan, AIR 1996 Raj. HC 80.
[195] Dr M. K. Gourikutty & etc. v. M. K. Madhavan and Ors, AIR 2001 Ker. HC (DB) 398.
[196] State of Punjab v. Surinder Kaur, 2001 ACJ 1266 (P&H-HC.

basically a loss of responsibility on the side of the hospital authorities. In ***R. P. Sharma v. the State of Rajasthan***[197], a woman died "*as a result of a mismatched blood transfusion; the State was held vicariously liable for the blood bank officers and the doctor who transfused the blood's negligence*". In ***Rukmani v. State of Tamil Nadu***[198], the Madras High Court held that in India, where the population is rising every second and family planning becomes a national programme, the doctors and the State must also be held liable for any damage resulting in an extra family birth, resulting in additional costs, resulting in a sterilisation operation failure.

Compensation may be given to an injured individual who is not treated in a government hospital or for death or injury caused by carelessness. The Honorable Supreme Court declared in the case of ***Paschim Bangal Khet Mazdoor Samity & Ors v. State of West Bengal***,[199] the provision of sufficient medical facilities to the individuals was a fundamental aspect of the government's duty under the welfare state. "*The lack of timely medical treatment for the person in need of such treatment by government hospitals is an infringement of his right to life guaranteed by Article 21 of the Indian Constitution*".

The appointment of alternative medical system practitioners [Ayurveda/Unani/Sidha] or of homoeopaths to hospitals who provide services in allopathy also amounts to negligence. It is the hospital's duty to provide qualified and experienced physicians for treatment. "*The Supreme Court of India has held that there is no scope for a person who is registered under the Indian Medicine Central Council Act, 1970 [Council for registration of practitioners of Indian Medicine – Ayurveda, Unani and Sidha] and enrolled on the State or Central Register of Indian Medicine to practice modern scientific medicine [allopathy] in any of its branches*." All these practitioners are allowed to take advantage of the numerous improvements in current technology such as radiology reports, laboratory research, etc., to practise in their own system. However, if any state law accepts, within the scope of the Indian Medical Council Act of 1956, registered in the State Medical Register, the certification of integrated course or other skills as a 'sufficiency qualification' for registration, it is allowed to practise allopathic medicine. This benefit would be granted only in those States which are privileged by the current State Law, under which Indian Medicine practitioners are enrolled in their State Medical Register for the practice of any system of medicine.

[197] R. P. Sharma v. the State of Rajasthan, AIR 2002 Raj. HC (Jpr. Bench) 104.
[198] Rukmani v. State of Tamil Nadu, AIR 2003 Mad. HC 352.
[199] Paschim Bangal Khet Mazdoor Samity & Ors v. State of West Bengal, 1996 (4) SC 260.

IX. CONCLUSION

Few would deny that delinquency, like in any other occupation, also needs to be dealt with severely in the medical area. It is not difficult to understand the causes. The sole difficulty is to define the parameters of "delinquency" that could lead to undesirable legal consequences. In the practice of medicine, the results of treatment are of limited importance for the imponderable. In setting the bounds of responsibility, two competing interests, each equally significant as the other, have to be balanced: One pertains to a professional's freedom to come to a judgement, and the other victims who do not seek to prevent the medical profession's presence of discretion but only its abuse and recklessness. In the process of achieving balance, Indian courts are lean, perhaps not unjustifiably, significantly in favour of doctors.

The law does not aim to intrude in the territory, which only medical professionals have the right to have, unnecessarily, and judges do not strive to force their own knowledge on them. "*The legal system does not take a hands-off approach either, scrutinising the actions of medical professionals and seeking to punish those who fall below the minimum standard; the test for judging the minimum standard is also heavily influenced by prevalent medical practises and opinions, as well as the available body of expertise, as of the relevant date. The standards are not overly high, and, in some situations, culpability is strengthened so that nobody is exempt from investigation*". In that respect, the law ardently protects the autonomy of medical practitioners and is fully aware that unnecessarily high prescription standards may cause a type of chill that is unwanted, but the law also strives to defend and protect a patient's interests by expecting a minimal degree of care.

CHAPTER 6: CONCLUSION AND SUGGESTIONS

Conclusion

It is just a question of establishing the parameters of "delinquency," which may result in legal ramifications if exceeded. When it comes to the practice of medicine, the outcome of treatment is of secondary importance due to the large number of imponderables. In the process of determining the parameters of liability, it is necessary to strike a balance between two competing interests, each of which is equally important as the other: one relates to the freedom of a professional in arriving at a judgement, and the other relates to the interests of the victims, in which the existence of discretion of the medical professional is not sought to be foreclosed, but only the abuse and recklessness with which it may be exercised, is sought to be foreclosed. The Indian courts, in the course of achieving a fair balance, tilt significantly in favor of the physicians, which is maybe not unjustifiably so.

The law does not aim to make any needless intrusions into the area that should be reserved only for medical experts, and courts do not strive to impose their own knowledge on those who are not qualified to do so. The legal system, on the other hand, does not take a hands-off approach and does scrutinize the actions of medical professionals, seeking to punish those who fall below the minimum standard. The test for determining the minimum standard is heavily influenced by the prevalent medical practices and opinions, as well as the body of knowledge available at the time of the relevant decision. The requirements are not excessively high, and by increasing the severity of the responsibility in specific situations, accountability is strengthened because no one can escape examination. While the law zealously protects the autonomy of medical professionals and recognizes that prescribing unreasonably high standards may have a chilling effect that is undesirable, the law also seeks to protect and safeguard the interests of patients who have a right to expect a minimum standard of care, which is known as the right to expect a minimum standard of care.

Here, in the above chapters the author has certainly attempted to prove the hypothesis so established at the very beginning of the research paper. They were, (i) the current legislations are inadequate in confronting the causes that lead to medical negligence and (ii) Legal position

with respect to the calculation or quantum of compensation in medical negligence. While concluding this paper, it becomes imperative to summaries the findings of this paper which led to this conclusion.

The first hypothesis states that current legislations are inadequate in confronting the causes that lead to medical negligence has been proved in 3rd chapter of the dissertation. Various legal frameworks have been scrutinized by the author and a well-read analysis has been carried out. As per Moni v. State of Kerala[200], "In the case of a medical man, negligence means failure to act by the standards of reasonably competent medical men at the time. There may be one or more perfectly proper standards, and if he conforms to one of these proper standards, then he is not negligent." As a result, there are three elements of negligence:

- a legal obligation on the part of the party complained of to exercise reasonable care towards the party complaining of the former's conduct within the scope of his duty;
- a breach of the said obligation; and
- consequential damage as a result of the breach of the said obligation.

There is no precise definition of medical negligence offered under any Indian legal framework, which provides doctors with a window of opportunity to avoid prosecution in some instances. There are majorly 3 legislations where penalty has been prescribed for negligence, note that no specific word as 'medical negligence' has been used nor any grave punishment for such an offence has been provided. 3 legislations are as follows:

Criminal Law:

Under Section 304A of Indian Penal Code, 1860, the penalty for whoever causes the death of a person by a rash or negligent act not amounting to culpable homicide is "imprisonment for a term of two years, or with a fine or with both"[201]. Also, various other circumstances have been mentioned such as negligence during administering anaesthesia, or vicarious liability shall be

[200] Moni v. State of Kerala, SA. No. 832 of 2000(G).

[201] Indian Penal Code, 1860, S 340A.

invoked in the case his/her employee causes negligent death of a patient. Though this law has been enacted, law also provides for defences which are provided under Sections 80 and 88 of the Indian Penal Code. Under Section 80(Accident in doing a lawful act) "nothing is an offense that is done by accident or misfortune and without any criminal intention or knowledge in the doing of a lawful act in a lawful manner by lawful means and with proper care and caution."[202] According to Section 88,"a person cannot be accused of an offense if she/ he performs an act in good faith for the other's benefit, does not intend to cause harm even if there is a risk, and the patient has explicitly or implicitly given consent."[203]

Consumer Protection Act:

According to the 1995 Supreme Court ruling in Indian Medical Association v. VP Shantha[204], the medical profession is now considered to be a "service" under the Consumer Protection Act of 1986, which was enacted to protect consumers. This defined the relationship between patients and medical professionals by granting contractual patients the ability to sue physicians for compensation if they were injured during the course of treatment in 'procedure free' consumer protection tribunals. According to Section 2(o) of the Consumer Protection Act, 1986, free services are not included under the definition of services.[205] In this way, the problem of medical negligence continues to persist.

Civil law:

The position regarding negligence in civil law is extremely significant because it encompasses a wide range of factors in its own right. This notion is relevant under tort law or civil law even if medical practitioners give free services, according to the courts. On the other hand, it might be argued that when the Consumer Protection Act terminates, tort law starts.

[202] Indian Penal Code, 1860, S 80.

[203] Indian Penal Code, 1860, S 88.

[204] Indian Medical Association v. VP Shantha, 1996 AIR 550.

[205] The Consumer Protection Act, 1986, S 2.

The Supreme Court of India decided in the case of the State of Haryana v. Smt Santra[206] that every doctor "has an obligation to behave with a reasonable degree of care and skill." The question of degree has always been significant in determining the distinction between carelessness under civil and criminal laws. It was also determined in one case that "for criminal liability under Section 304-A, it is required that the death should have been the direct result of a rash and negligent conduct of the accused, without the participation of any other person" in order to impose criminal liability. Despite the fact that medical negligence is punishable by law, mistakes have still been committed. For example, the standard of appropriate care is applied in a proportional manner to the skills of an ordinary doctor. However, if a person is paying greater fees in comparison to the doctor's specialization and has competence in a certain subject, the court should make a decision based on the expectations of patients rather than the expectations of an ordinary doctor. This will result in rash decisions where doctors will be granted an advantage against the tyranny of the patient's pain and grief.

The second hypothesis read as a legal position with respect to the calculation or quantum of compensation in medical negligence is not adequate has been discussed in the 5th chapter of this dissertation. The fact that courts continue to rely on the formula of the perfect mathematical meaning for the computation of compensation is a given, but it is possible that this formula will not be correct in the situation of medical negligence. In contrast, as previously stated, the medical specialization of physicians raises the expectations of their patients, who in turn raise their own expectations of their doctors in a similar manner.

The principle of "restitutio in integrum," which can be translated as "ensuring that the person seeking damages as a result of a wrong committed against him/her is in the position that he/she would have been in if the wrong had not been committed," serves as the foundation for calculating compensation under common law. This indicates that the victim should be paid for any financial losses incurred as a result of the doctor's or hospital's carelessness, as well as for any future medical expenditures incurred, as well as for any pain and suffering experienced by

[206] State of Haryana v. Smt Santra, AIR 2000 SC 1888.

the victim.[207] As a result, not only should the mathematical calculations be taken into consideration, but so should other considerations. Furthermore, if we consider only these restricted considerations, the individual who receives free services will be entitled to a little amount of compensation, which may not be equitable in other circumstances. But the conundrum that courts confront when deciding whether or not to award compensation in medical negligence cases is primarily attributable to the following factors: (a) It is necessary for the law to defend the rights of patients, and (b) it is also necessary for the law to grant appropriate autonomy to a profession that is, by definition, an imperfect science. A few pieces of legislation need to be amended in order to eliminate this ambiguity in the law, provide an appropriate remedy that is acceptable to all sides, and achieve a mutually agreeable settlement.

Thus, with the assistance of these statutes and landmark decisions, the author has completed the dissertation by demonstrating the hypothesis that was previously stated. The author would like to offer many ways in which the legislation might be changed and amended to better meet contemporary requirements and trends, while taking into consideration prior experiences and court decisions that have become obsolete as a result of uncontrollable circumstances such as global warming. With the progress of technology, medical research has also thrived, which necessitates a revolution in the way in which responsibilities are placed on medical professionals that are larger than they were previously.

The purpose of the research is to analyse and assess the present condition of medical negligence legislation, as well as how well they fulfil the contemporary needs of the medical community. The findings demonstrate how the courts and quasi-courts have dealt with the cases that they have heard, and how those responses have been utilized to set precedents for future cases that are brought before them. When it comes to preserving and prolonging a person's quality of life, medical practitioners have traditionally been regarded as Earthly Gods. This has continued to this day. For as long as this profession has been, there have been reports of medical negligence and omission on the part of doctors and nurses. The purpose of this article is to examine the nation's legislative and legal framework for medical negligence, and to offer suggestions on how to make it better in the future.

[207] Meghana S. Chandra, Progress in Medicine: Compensation and medical negligence in India: Does the system need a quick fix or an overhaul?, NCBI.

Suggestions

The author has earlier suggested in this paper, that several changes should be made and few things should be taken into account. In the below given paragraphs the author shall suggest several reforms which shall be crucial for medical negligence legal framework in India.

First, new laws should be drafted from scratch, taking into consideration all of the stakeholders' previous experiences as well as medical advancements in terms of science and technology. In the absence of a clear legal framework, several doctrines have been established by courts; as a result, such doctrines should be given legal sanction, and a clear law should be enacted for 'medical negligence' in particular, defining the responsibility of doctors and ensuring that patients receive the bare minimum of fair treatment during trials.

The second suggestion is the creation of tribunals on a regional scale. When it comes to civil court work, it has been extremely sluggish, and judges have not been able to dispose of cases in a timely manner. These types of instances involving medical negligence necessitate particular and prompt attention since, in many circumstances, these treatments are expensive, and many people cannot afford the further treatment that may be necessary as a result of the carelessness unless they obtain compensation. As a result, such matters should be heard by tribunals that have been formed specifically for this purpose. Also, a recommendation may be made regarding the composition of the panel of judges, with the majority of the judges being non-medical and the minority being from the medical profession, so that the medical rationale can be applied to the negligence in the case that is necessary. It is possible, however, to substitute a system of expert opinion for the composition of the panel in this situation.

Third, a system should be devised to take into account a 'sub-standard care'. It should be treated with the same sincerity as medical negligence. Yet another flaw in this system is that it does not address the issue of 'below-standard care.' Compensation may only be sought for injuries that occur as a direct result of the negligence of medical professionals; however, there is no recourse available for substandard treatment that does not result in any direct harm to the

patient or their family. To put it another way, the existing system does not have any safeguards to ensure that high-quality service is given and kept up to date at all times. It is not addressed in cases when there has been no carelessness, but the service received has been substandard and has resulted in the patient's health deteriorating further or having an adverse effect on them in some other way that is not a direct result of the treatment.

Fourth, there should be a distinction between compensating ordinary medical negligence and compensating extreme medical malpractice. Depending on the doctor's experience, competence, and expectations, a fair standard of care should be created based on the expectations of patients who are receiving treatment from them and putting their trust in them unconditionally. It has previously been established by the Supreme Court of India that no sum can be considered reasonable and appropriate in an absolute sense. Whatever the circumstances and context, the courts must be willing to consider each case on its own merits, so that the rulings are just, equitable, rational, and wise in the long run. In situations of extreme carelessness, when a person remains in a bad state for the rest of his or her life, a medical practitioner's suspension of merely a few months or years is not adequate punishment. The Medical Council of India should immediately revoke their license indefinitely and without notice. The patient, on the other hand, does not qualify for a just judgement in this case, as previously stated. This should be in addition to any compensation that may be due to the patient as a result of the gross negligence of the doctor.

Fifth, despite the fact that people are prone to making mistakes, and particularly when dealing with the most complicated organism on the planet, humans, physicians do make mistakes. However, it should not be treated lightly since it has the potential to be deadly and result in their deaths. Therefore, a punishment should be imposed on physicians in order to drive them to be more honest in their job and to refrain from engaging in malpractice. Obviously, in the rarest of situations, they are done rashly on the surface of things, but these conditions should be distinguished from the ones discussed above, and a legislation should be enacted to address them specifically.

Scope of future research

Despite this, there are a number of limitations and gaps that require more and more thorough research. Our research seeks to provide light on the many laws governing medical negligence in India, and we hope to accomplish this aim. Medical training and experience, as well as the legal framework and the aim of these laws, are complicated not only by differences between theoretical reasoning and reality, but also by the uniqueness that doctors possess in terms of their training and experience. It is the absence of complete information on the part of courts and people regarding the appropriate level of care to be offered to their clients that characterizes the real world. As a result, there are more problems than the legal system is capable of resolving at any given time. In the absence of reliable signals to the agents involved, the system becomes entangled in issues such as defensive medicine and rising health-care costs, which further destabilize the system. This research will be beneficial in terms of the ideas it gives, which may be further investigated utilizing the imperfect information provided with the assistance of statistical techniques, as well as the related legal reasoning, in order to present a more complete picture. A committee may be created at the national level to explore these concerns in more depth, which will prove to be a beneficial exercise in addressing these difficulties to a greater extent.

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