Page 3167 - 3177

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Medical Negligence: An Outlook on Contemporary India

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ABSTRACT

According to a report by the World Health Organization, in India one in 10 hospital admissions leads to an adverse event and one in 300 admissions in death. Increase in medical negligence cases is largely attributed to awareness of medical knowledge, rights of patients and also the rise in medical cost. It is not the doctors alone who are responsible but rather the hospital, nurses, consultants, service providers and the like.

Initially the paper deals with the issue of doctors prescribing medicines without personal examination. The principles of Patient Autonomy and Right to Self Determination govern the modern medical ethics. This can lead to the fear of legislation in doctors. The essence of this kind of legislation takes root from Art. 21 which guarantees the "Right to Life" of the citizen. The doctor can further be held liable under Sec. 304A, 320 and 80 of IPC. The number of healthcare seekers have drastically increased in India as opposed to the diminishing number of qualified medical personnel. This has increased the workload of the doctors. In such a situation the doctor should at least have the freedom to prescribe a temporary relief to the patient based on the symptoms without having to personally examine him.

Though India produces about 50,000 medical practitioners a year, there seems to be a problem of lack of qualified staff to assist the doctor, who are capable enough to handle trivial matters which is the second issue the paper deals with.

Furthermore, the paper throws light on the complexities of handling emergency cases in the hospital. In USA there exist certain enactments such as EMTALA and COBRA which guarantee medical attention to all who arrive at an emergency department. In India, we have recognized a rule that a failure on the part of any hospital to provide timely medical treatment is a violation of a person's Right to Life. However, the extent to which this rule is complied with is a matter of fact.

The next problem the medical field faces are a lack of Primary Health Centers and pre-medical assistance. As on 31st March 2014, at an all-India level there are 25020 Primary Health Centers (PHCs) functioning which is far below the required number. In 2013, the Automotive Industry Standard Committee in India deliberated on the pathetic condition of ambulances in the State. There is no standardization for ambulance design and the

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ambulance specifications are written by medical specialists who cannot translate the user requirement to automobile terminology. The existing laws also allow goods vehicles to be treated as ambulances.

These issues are not without solution. Why does India remain backward in meeting the basic needs of the society? Citizens are the wealth of the Nation and their health should be given utmost importance. The Government should improve on the already existing laws and take up the suggestions put forward by various Law Commissions and Committees to handle this situation successfully.

Keywords: *Medical negligence, doctors.*

I. INTRODUCTION

According to Black's Law Dictionary "Negligence is the omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do or doing something which a prudent and reasonable man would not do." Medical negligence relates to some irregular conduct on the part of any member of the profession or related service in discharge of professional duties. Generally, negligence is the breach of a legal duty to care. Legal duty means the duty the law gives to every person to respect the legal rights of the other. One must always keep in mind the maxim **"ubi jus ibi remedium"**[3] while looking into this aspect.

The liability of the person committing the wrong can take the following forms:

i. **Civil Liability:** When a person who possesses special knowledge and skill in a field uses it to treat another, then he owes a duty of care to that person. If a wrong is committed by him in this period, then he is liable to pay damages in the form of compensation. Dr. Kunal Saha's case, in which the Supreme Court awarded an unprecedented amount, 60.8 million rupees plus 6% annual interest for each of the fifteen years the case was fought, was a landmark turn in India's medical negligence law.

ii. **Criminal Liability:** If an occasion arises wherein the patient has died after the treatment, then a criminal case can be filed under Section 304A of the IPC for allegedly causing death by rash or negligent act. Criminal liability can also be imposed under Sections 52, 91, 104, 337 and 338 of the same Act and each of these purports to those negligently done acts which cause harm to others.

[3] Where there is a right, there is a remedy.

Earlier, hospitals were not held liable for the negligent acts of its professional staff. This changed in England after the case of Gold v. Essex County Council[4]followed by Cassidy v. Ministry of Health[5].In India V.P. Shanta was a landmark case. Further, the hospital authority is also liable if it employs unqualified staff. This was held in Spring Meadows Hospital v. Harjot Ahluwalia[6]. Other facilities and services provided such as ambulance service, oxygen cylinders, cardiac monitors, laboratory results etc should be maintained in perfect order, as their failure may lead to death or damage to the patient. M. Ramesh Reddy v. State of Andhra Pradesh[7], Mayo Hospital v. Sunil Tiwari[8]and Geethu Sapra v. B.L. Kapoor Memorial Hospital[9]are cases in which these aspects were discussed.

II. Clinical ethics and law

These are disciplines with overlapping concepts, yet each discipline has unique parameters and a distinct focus. Ethical norms may be derived from:[10]

- Law
- Institutional policies/practices
- Policies of professional organizations
- Professional standard of care and fiduciary obligation.

There are two primary types of potential civil actions against health care providers for injuries resulting from health care:

a) **Lack of Informed Consent:** The ethical requirement to obtain a patient's informed consent is founded on the philosophical theory of **Patient Autonomy**. Its origins can be traced to philosophic treatises of the French and English Enlightenment. It is an ethical imperative to promote personal well-being and **self determination**. This principle has been expressed in law by Justice Cardozo[11].

In USA, patient autonomy has been linked with the principle of **"Sanctity of Life".** Accordingly, one should respect the competent patient's autonomy and right to refuse medical intervention. In Bouvia v. Superior Court[12], it was decided that a competent patient has the right

[4] [1942]2 KB 293
[5] (1951)2 KB 343
[6] AIR 1998 SC 1801
[7] 2003 (1) CLD 81
[8] 1997 (3) CPR 574
[9] (2005) 10 SCC 549
[10] https://depts.washington.edu/bioethx/topics/law.html
[11] Schloendorff v. Society of New York Hospitals(1914), 105 NE 92
[12] (1986), 225 Cal Rptr 297

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to refuse any medical treatment, including nourishment and hydration. This principle can be problematic when patients appear to be cognitively competent but unable to make use of the information because of their emotional state.

For informed consent to be valid the patient must be competent. The assessment of a patient's decision-making capacity is usually implicit in the doctor-patient interaction and does not require a formal testing. The law presumes patient competence. However, competent patients should not have treatments imposed on them and incompetent patients should not be allowed to suffer the harmful effects of their bad decisions. There should be a balance between the two.

Article 21 of the Indian Constitution guarantees "Right to Life" which has its essence from "Right to Choice". In every medical treatment there are some inherent risks and the patient has an absolute right to decide what should and should not be done to his body. It confers two major rights through which a patient may refuse treatment i.e. "right to privacy" and "right to self determination". Under Article 25(1) the person is invested with the freedom of conscience and religion which authorizes him to refuse treatment, if it goes against the interest of his belief; even though this denial leads to death.

In the landmark case of Indian Medical Association v. V.P. Shantha[13], the Supreme Court has brought medical profession within Section 2(1)(o) of the Consumer Protection Act (CPA), 1986. In Dr. P.S. Hardia v. Kedarnath Sethia[14] the court held that simply taking signature on consent paper is not sufficient.

b) Standard of Care: When a doctor attends to his patients he owes the following duty of care as held in Trimbak Bapu case[15] and A.S. Mittal case[16]:

- In deciding whether to undertake the case
- In deciding what treatment to give
- In the administration of the treatment.

The standard of care of a professional man can be tested using the Bolam Test[17] in which the court will compare the standard of medical care given by the medical professional in question with that of a similarly qualified and experienced professional in a similar circumstance[18]. In India, it was clearly explained in Jacob Mathew's case[19] and was further used to determine A.H.

[13] AIR 1996 SC 550
[1414] F.A No. 182 of 2000
[15] AIR 1969 SC 128
[16] AIR 1989 SC 1570
[17] Bolam v. Friern Hospital Management Committee, [1957]2 All ER 118
[18] Medical Negligence and the Law in India: Duties, Responsibilities and Rights – Tapas Kumar Koley
[19] (2005)6 SCC 1

Khodwa v. State of Maharashtra[20], Poonam Verma v. Ashwin Patel[21], Vinitha Ashok v. Lakshmi Hospital[22]etc.

The **'Neighbor Principle'** from Donoghue's case relies on proving that it was reasonably foreseeable that if the defendant did something negligent, it would hurt the plaintiff. Roe v. Minister of Health[23] is a decision which had a significant influence on Common Law and is a classic example of foresee ability. This lack of foresee ability is a major factor in determining negligence. The foresight of a medical professional depends on their qualification and years of experience. However, medicine is an 'inexact science' where it is difficult to foresee an event.

Though generally, the burden of proof rests on the patient, there are circumstances where the negligence is to such an extent that it is obvious that the physician was negligent. The principle of "**Res Ipsa Loquitur**"[24] can be invoked here.

III. INEFFICIENT RESOURCES

India has the largest number of medical colleges in the world and it produces among the largest number of doctors in the developing world. India is also the 3rd largest producer of pharmaceuticals by volume in the world[25]. Despite all these resources, the majority of citizens have very limited access to quality health care and there are low levels of immunization. It has also been estimated that almost two-thirds of the medicines prescribed by doctors are irrational or unnecessary, and is to simply satisfy the high profit motives of private providers. The increasing market dependence to seek healthcare makes the poor postpone and forgo attention for medical care. The increased private control and marketisation of healthcare is not only making access to healthcare for the poor more difficult but also given the complete absence of any regulation of private healthcare and lack of ethical conduct of professionals, it is making healthcare like any other commercial commodity.

As per the information provided by Medical Council of India, the total number of registered doctors is 9,36,488 as on December 2014[26] and it gives a doctor-patient ratio of 1:1674 against the WHO norm of 1:1000[27]. Available data from National Sample Survey Organization suggest

[20] AIR 1996 SC 2377
[21] AIR 1996 SC 2111
[22] AIR 2001 SC 3914
[23] [1954]2 All ER 131
[24] The thing speaks for itself
[25] Department of Pharmaceuticals. Annual Report 2020-2021, Ministry of Chemicals and Fertilizers, Government of India
[26] http://www.indiamedicaltimes.com/2015/03/13/india-has-9-36-lakh-doctors-of-modern-medicine/
[27] Grim picture of doctor-patient ratio, Neetu Chandra Sharma, India Today, indiatoday.intoday.in/story/grim-picture-of-doctor-patient-ratio/1/654589.html

that a majority of the physicians work in the private sector. Qualified doctors and institutions are not readily available in remote, rural and tribal areas because people do not have ability to pay and there is a lack of social infrastructure[28]. Thus those areas with the greatest healthcare needs have very poor access to functioning health services, both government and public.

Nearly 27% of the total deaths in India happen with no medical attention at the time of death, according to the 2013 civil registration data released by the Census Directorate[29]. The thousands of community medical centers do not have facilities to do even minor surgeries which will save a person's life. A majority of the population approached the private sector for outpatient curative for minor ailments. However, when it came to obtaining immunization or antenatal care, most people irrespective of their income status went to government institutions[30].

The brain drain of doctors can be blamed for a lack of robust health system within the country, linked with poor access to quality healthcare for the rural population. Shortage of doctors can also be attributed to factors such as preference to work in private hospitals, study and work abroad. Also, Indian students, who have gone abroad after November 18, 2021, to study medical education, might not get a license to practice in India upon their return. New norms framed by the Indian medical education regulator National Medial Commission (NMC) debars them from appearing in the Exit Exam and practice medicine here[31].

The differences between rural and urban indicators of health status are well known. One of the long-standing problem of India has come to fore with the report of the Central Bureau of Health Intelligence's National Health Profile (NHP) 2013. It has been revealed that in our country only 33% of government doctors are available in the rural areas where nearly 70% of the population lives[32]. Rural healthcare is thus one of the biggest challenges in India.

The Global Strategy on Human resources for Health: Workforce 2030 Report[33], notes that adequate investment in health workforce along with availability, accessibility, acceptability and coverage leads to overall social and economic development along with improvements in

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[28] planningcommission.nic.in/aboutus/committee/strgrp/stgp.../

[29] 27% of deaths in India for want of medical attention, Sivakumar B, Times of India, https://timesofindia.indiatimes.com/india/27-of-deaths-in-india-for-want-of-medical-attention/articleshow/49474537.cms

[30] planningcommission.nic.in/aboutus/committee/strgrp/stgp.../11_Chapter%209.doc

[31] NMC quashes hopes of Indian students with foreign medical degrees to practice in India, Jeevan Prakash Sharma, Outlook, https://www.outlookindia.com/national/nmc-squashes-hopes-of-indian-students-with-foreign-medical-degrees-to-practise-in-india-news-189743

[32] With only 33% govt doctors in rural India, 'health for all' is a tough task, Reetu Sharma, One India, http://www.oneindia.com/feature/with-only-33-govt-doctors-rural-india-health-all-is-toug-1485567.html

[33] Karan, A., Negandhi, H., Hussain, S. et al. Size, composition and distribution of health workforce in India: why, and where to invest?. Hum Resour Health **19**, 39 (2021). https://doi.org/10.1186/s12960-021-00575-2

population health.

The Acute Critical Care Course (ACCC), developed in the early 1980s in Europe, has come as a boon for medical institutions abroad by reducing the death rate of patients by nearly 10 per cent. A study by the Harvard University in the year 2017 showed that nearly 50,00,000 deaths occur in India annually due to medical errors triggered by lack of practical knowledge among the doctors and nurses to handle patients when brought to the hospital. The ACCC aims to train the medicine specialists and the surgeons of various specialisation such as surgical, gynaecology, orthopaedics and emergency to suspect and identify patients at a risk of deterioration.[34]

IV. Emergency care and pre-medical assistance

The Supreme Court of India as long back as 1989 observed in Parmanand Katara v. Union of India[35] that when accidents occur and the victims are taken to hospitals or to a medical practitioner, where they are not taken care of on the ground that the case is a medico-legal case and the injured should go to a government hospital. The Supreme Court emphasized the need for making it obligatory for hospitals and practitioners to provide emergency medical care. The Supreme Court reiterated its view in Pashchim Banga Khet Mazdoor Samithi v. State of West Bengal[36]. The National Consumer Redressal Commission has also decided in like manner in Pravat Kumar Mukerjee v. Ruby General Hospital[37].

Indifference towards victims of accidents and those in emergency medical conditions and even women under labor who are about to deliver is not peculiar to India but is prevalent in other countries. In USA, there is a statute called Emergency Medical Treatment and Labor Act (EMTALA) which was enacted by introducing it in 1986 into the Consolidated Omnibus Budget Reconciliation Act (COBRA), 1985. This Act is also known as the Patient Anti-Dumping Act. It imposed a mandatory duty on hospitals to give medical treatment to patients in emergency medical condition and women under labor, failing which the defaulter can be punished under the criminal law.

The death of Ajay Henry[38] aged 22, on 8th January 2014 following a car accident in Kollam was an incident which brought about huge outcry against the state of emergency care in India.

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[34] India's medical error deaths, nearly 5 mn a year, can be cut by 50%: Expert, Business Standard, https://www.business-standard.com/article/current-affairs/india-s-medical-error-deaths-nearly-5-mn-a-year-can-be-cut-by-50-expert-118102800193_1.html

[35] 1989 ACJ 1000 (SC)

[36] AIR 1996 SC 2426

[37] National Consumer Disputes Redressal Commission, New Delhi, OP.NO 90 of 2002

[38] Protest against 'medical negligence', The Hindu, http://www.thehindu.com/todays-paper/tp-national/tp-kerala/protest-against-medical-negligence/article5672293.ece

There were no doctors present at the District Hospital's casualty wing and he was asked to be transferred to another hospital where he was pronounced dead within minutes of reaching. This situation apart from gross negligence, also points out the following:

- The general conviction that medico-legal cases[39] would be entertained only by government hospitals.
- Exposes the sorry state of pre-hospital medical care and the basic provisions for basic life support.
- The lack of a standard protocol to stabilize the traumatized patients, when a medical practitioner is not immediately available and for a transfer to a facility for expert management.

Pre-medical assistance is deficient in our country. According to Section 2(11) of the CPA 2019, 'deficiency' means any fault, imperfection, shortcoming, or inadequacy in the quality, nature, and manner of performance which is required to be maintained, by or under any law for the time being in force, or has been undertaken to be performed by a person, in pursuance of a contract or otherwise, in relation to any service. While countries like Malaysia, Dubai, and Europe etc provide ambulances with multi-stretcher, integrated tooled roof and interiors with appropriate storage units, India still allows goods vehicles to be converted as ambulances for passenger application without incorporating essential safety features in patient compartment like side-door, forward-backward seating, proper air conditioning, certified electrical system etc.

In comparison to most of the developed countries in the world, India showed better availability of basic necessities. But instances of medical negligence during covid leading to rise in mortality rates did exist. Lack of adequate size of basic necessities including oxygen masks, ventilator facilities, lifesaving medicines were witnessed in these times. On June 25, 2021, two associates from Kanpur were found guilty of causing the death of a patient by negligence. The police lodged FIR and barred the two under the provision of 304(A) IPC (causing death by negligence which does not amount to culpable homicide).[40] August 2017 saw Gorakhpur's BRD Medical College in the spotlight for the death of at least 60 children allegedly due to lack of oxygen, and in September came the news of 49 deaths between July 20 and August 21 in Farrukhabad's RML Hospital due to lack of oxygen.[41]

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[39] Any case of injury or ailment where some criminality is involved.

[40] Aryaman Tripathi, Medical Negligence During COVID 19: Did we Successfully Implement Section 304A IPC, Academike, https://www.lawctopus.com/academike/medical-negligence-during-covid/

[41] 30 infants died in 33 days in UP's Farrukhabad: A ground report, Prerna Katiyar, The Economic Times, https://economictimes.indiatimes.com/news/politics-and-nation/how-30-infants-died-in-33-days-in-ups-

The Ministry of Road and Transport and Highways, Government of India set up five Working Groups on 4Es of road safety i.e. Education, Engineering, Enforcement and Emergency Care on the recommendation of the National Road Safety Council (NRSC) in 2013[42]. The Working Group on Emergency Care in its report observed that the real concept of an ambulance is missing in India. Existing ambulances are more like transport vehicles and any vehicle suitable to lay a patient is called an ambulance without consideration to the overall ambulance design. Research has shown that ambulances are more likely to be involved in motor vehicle collisions resulting in injury or death than either fire trucks or police cars[43]. Unrestrained occupants, particularly those riding in the patient-care compartment are vulnerable. It is therefore, all the more necessary in an ambulance to take care of occupant safety, patient care ergonomics, medical equipment selection and placement, vehicle engineering and integration etc.

Yet another pre-medical assistance which is absent in the country is the motorcycle ambulance. These are a type of emergency vehicle which either carries a solo paramedic or first responder to a patient; or is used with a trailer or sidecar for transporting patients[44]. Its major advantage is that it is able to respond to a medical emergency much faster than a car or van in heavy traffic, which can increase the survival rates of patients. Hong Kong, Norway, and Israel are examples of places which provide such services to its citizens.

Motorcycle ambulances were initially used by the British, French and Americans during World War I. Australia, Brazil and Germany has utilized this facility to suit the narrow streets and for quick responses during accidents on and near highways where there is heavy traffic and it would not be easy for an ambulance to arrive there.

This kind of a service is of recent origin in India. Karnataka launched the two-wheeler ambulance service on 15th April 2015 with an initiative to reach the patient in just ten minutes and became the first state to do so. At present, States like Kerala and Chhattisgarh also have launched the project. Health specialist at UNICEF says that the motorcycle ambulance project was initiated last year and supported by UNICEF in collaboration with an NGO, Saathi Samaj Sevi Sanstha, and the Health Department of the state government in Chhattisgarh[45] and it has helped to save lives in the forests and to provide immediate medical assistance to pregnant

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farrukhabad-a-ground-report/articleshow/60442904.cms

[42] Constructional and Functional Requirements for Road Ambulances National Ambulance Code), Automotive Research Association of India, Ministry of Road Transport and Highways, nisc.**gov**.in/PDF/AIS_125.pdf

[43] https://araiindia.com/hmr/.../422201344800PMDraft_AIS-125_F_April_2013.pdf

[44] Motorcycle Ambulance, Wikipedia: The Free Encyclopedia, https://en.wikipedia.org/wiki/Motorcycle_ambulance

[45] Motorcycle-ambulances help save lives in Chhattisgarh forests, IANS News Agency, http://indianexpress.com/article/lifestyle/health/motorcycle-ambulances-help-saves-lives-in-chhattisgarh-forests-2935290/

women who have to walk miles to reach the nearest hospital. Organizations like the World Health Partners are currently transforming commonly available motorcycles in rural Bihar, into an ambulance by building an affordable and detachable sidecar attachment equipped with oxygen and other emergency medical supplies[46]. This service not only provides emergency transportation, but will also serve as a business opportunity for local entrepreneurs.

Negligence on lives of tribal population is contemporaneously on discussion only on an event of negligence being aired. But apart from news on limelight there are double the cases happening behind closed doors.

Tribal population are not integrated into the national mainstream of socioeconomic activities, invariably leading to their lower educational (41% Illiteracy) and economic attainment (41% Below Poverty Line); a life often marred by lack of material circumstances and lack of access to public utilities and services. Their geographically isolated habitats often compound their problems. Moreover, deleterious social beliefs and cultural practices that often remain entrenched in their practices have telling effects on their health and health-seeking behaviour[47].

The tribal woman lost all her three babies within a span of 24 hours, due to poor health infrastructure and medical negligence by the gynecologist on call duty in a tribal village in Kerala.[48].

V. Conclusion

A patient approaching a doctor expects medical treatment with all the knowledge and skill that the doctor possesses to bring relief to his medical problem. The relationship takes the shape of a contract retaining the essential elements of tort. Thus, it is not only the doctor who owes a duty to the patient but the hospital as a whole.

The Law Commission of India, suo motto took up the subject of 'Emergency Medical Care to Victims of Accidents' and Other Emergencies' in its 201st report and formulated a model law "The Medical Treatment After Accidents and During Emergency Medical Condition Act, 2006". It appears that none of the state governments have taken the call till now.

Though a lot of policies and programs are being run by the Government, the problem is due to

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[46] Fabricate Moto-Ambulances for Rural Poor in India, World Health Partners, https://www.globalgiving.org/projects/moto-ambulance-**rural**-india/

[47] Kumar MM, Pathak VK, Ruikar M. Tribal population in India: A public health challenge and road to future. J Family Med Prim Care. 2020 Feb 28;9(2):508-512. doi: 10.4103/jfmpc.jfmpc_992_19. PMID: 32318373; PMCID: PMC7113978.

[48] Tribal woman loses triplets due to medical negligence, Express News Service, The New Indian Express, https://www.newindianexpress.com/states/kerala/2015/sep/04/Tribal-Woman-Loses-Triplets-Due-to-Medical-Negligence-809385.html

gaps in the implementation of the same, because of which the success and effectiveness of such programs in questionable.

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