CASE NO.:
Appeal (crl.) 778 of 2004
PETITIONER:
Dr. Suresh Gupta
RESPONDENT:
Govt. of N.C.T. of Delhi & Anr.
DATE OF JUDGMENT: 04/08/2004
BENCH:
Y. K. Sabharwal & D. M. Dharmadhikari
JUDGMENT:
J U D G M E N T
(Arising out of SLP(Crl.) No. 2931 of 2003)

Dharmadhikari J.

Leave to appeal is granted.

The appellant who is a Doctor (Plastic Surgeon) is in the dock as an accused on the charge under Section 304 A of the Indian Penal Code [for short the 'IPC'] for causing death of his patient on 18.4.1994. The patient was operated by him for removing his nasal deformity. It may be mentioned at the outset, that the Anesthetist who was assisting the surgeon in the operation was also made co-accused but it is reported that he died pending the trial. The proceedings, therefore, stand abated against him.

The appellant urged before the Magistrate that the medical evidence produced by the prosecution, does not make out any case against him to proceed with the trial. The learned magistrate in deciding to proceed with the trial recorded following reasons in the impugned order dated 28.11.1998 passed by him :-

"Postmortem report is very categorical and very clear and it has been clearly mentioned therein that death was due to the complication arising out of the operation. That operation was conducted by both the accused persons. It is also clear from the material on record that deceased was young man of 38 years having no cardiac problem at all and because of the negligence of the doctors while conducting minor operation for removing nasal deformity, gave incision at wrong part due to that blood seeped into the respiratory passage and because of that patient immediately collapsed and died and it was also attempted to show by the accused persons that he was alive at that time and was taken to Ganga Ram Hospital for further medical attention.

It is clear from the record that patient had actually died at the clinic of the accused and therefore, I am of the opinion that there are sufficient grounds on record to make out a prima facie case against both the accused for commission of offence under Section 304A IPC. Let notice be served accordingly."

[Emphasis supplied]

As the Magistrate decided to proceed with the trial, the doctor approached the High Court by petition under Section 482 of the Code of Criminal Procedure. The High Court refused to quash the criminal proceedings and upheld the order of the Magistrate, although it records that

the Metropolitan Magistrate was obviously wrong, in the absence of any medical opinion, in coming to a conclusion that the surgeon had given a cut
at wrong place of the body of the patient at the time of operation leading to

blood seeping into the respiratory passage and blocking it resulting in his
death. The High Court, however, declined to quash the proceedings against
the doctor for the alleged criminal liability. In the impugned order dated
1.4.2003, it recorded its reasons thus :-
"In the present case two doctors who conducted the post-mortem examination have taken an emphatic stand which they have reiterated even after the Special Medical Board opinion, that death in this case was due to 'asphyxia resulting from blockage of respiratory passage by aspirated blood consequent upon surgically incised margin of nasal septum.' This indicates that adequate care was not taken to prevent seepage of blood down the respiratory passage which resulted in asphyxia. The opinion of the Special Medical Board is not free from ambiguity for the reasons already given. Such ambiguity can be explained by the concerned doctors when they are examined during the trial."
Learned senior counsel Shri Ashok Desai appearing for the doctor, has taken us through the contents of the medical opinions produced by the
prosecution with the complaint and some medical books and decided cases to submit that accepting the entire case of the prosecution, as has been laid
before the trial magistrate, to be true, no case for convicting the doctor for
criminal negligence under section 304A IPC has been made out. He submits
that in the larger interest of medical profession, the criminal proceedings
instituted against his client deserve to be quashed.
Reliance is placed on the House of Lords decision in the case of R. vs. Adomako [1994 (3) All E. R. 79]; Suleman Rehman Mulani vs. State of Maharashtra [1968 (2) SCR 515] and Laxman Balkrishna Joshi vs. Trimbak Bapu Godbole [1969 (1) SCR 206].
We have also heard learned senior counsel Shri Harish Chandra for the prosecution, who supported the view taken by the Magistrate and the High Court that the surgeon was guilty of gross negligence in giving an incision at the wrong place and did not take necessary precautions in the
course of surgical operation to prevent seepage of blood down the respiratory passage of the patient and the resultant death by asphyxia.
It is settled position in law that the inherent power of the High Court under section 482 Criminal Procedure Code for quashing criminal proceedings can be invoked only in cases where on the face of the complaint or the papers accompanying the same no offence is made out for
proceeding with the trial. In other words, the test is that taking the allegations and the complaint, as they are, without adding or subtracting

anything, if no offence is made out, the High Court will be justified in
quashing the proceedings [See Municipal Corporation of Delhi vs. Ram Kishan Rohtagi (AIR 1983 SC 67); and Durgs Inspector vs. B.K. Krishnaiah (AIR 1981 SC 1164)]
To decide whether on the basis of the complaint and the medical opinion produced along with it, any offence is made out or not, it is necessary to examine the papers produced with the complaint. The patient
died in the course of surgical operation on 18.4.1994, but the post-mortem
was conducted on 21.4.1994. By that time rigor mortis had almost passed off. The post-mortem report gave opinion on the cause of death by recording thus :-
"Asphyxia resulting from blockage of respiratory passage by aspirated blood consequent upon surgically incised margin of nasal septum. The cause of death to the best of my knowledge and answers to the question put by IO."
A Special Medical Board of four eminent doctors was constituted by the investigating agency out of which three recorded their unanimous

opinion as under :-
After the perusal of all the documents produced before the Committee, we are of the view that the death of Mr. Siavash Karim Arbab, occurred due to sudden cardiac arrest, the direct cause of which (Cardiac Arrest) cannot be ascertained. However, possible cause leading to cardiac arrest can be as follows :-
1. Hypotension due Head-up-Position
2. Adverse drug reaction
3. Hypoxia
Death due to Asphyxia resulting from blockage of air passage secondary to ante-mortem aspiration of blood from the wound is not likely in the presence of cuffed endo-tracheal tube of proper size (8.5), which was introduced before the operation and remained in position till the patient was declared dead in Sir Ganga Ram Hospital, as per statements of members of the operating team and available records. In the post-mortem report there is presence of clotted fluid blood in respiratory passage, which invariably occurs ante-mortem due to aspiration from operation site. However, the presence of fluid and clotted blood in the respiratory passage, as noted in the post-mortem report, due to trickling of decomposition bloody fluid and some clot present in the nostril from the site of incision in the nose, cannot be ruled out after the tube is taken out. It is worth mentioning in the present case that the death occurred on 18.4.1994 at 2.30 p.m. and the post-mortem was conducted on 21.4.1994 at 12.20 p.m. when sufficient degree of decomposition had started.
Sd/- Dr. Bharat Singh Sd/- Dr. Rizvi Sd/- P.L. Dhingra
Chairman Member Member
[Emphasis supplied]
One of the members of the doctors team Prof. Jagannatham gave a separate report which reads as under :-
"After going through he relevant papers/documents and surgery and anaesthesia notes, it was observed that, what medical care was actually extended to the patient from 5 a.m. to 8.30 a.m. on 18.4.1994 at Delhi Plastic Surgery Clinic. It is surprising that the patient's physical status belonged to ASA Grade-I. The actual cause of

cardiac arrest on the table noticed immediately after the start of operation, was not clear and it still stands as enigmas whether the surgeon had given any adrenaline infiltration to the patient or originally planned to do the surgery under local anaesthesia could not be decided. There is no mention about the use of inhalation anaesthesia during the surgical procedure under the general anaesthesia.

However, both anaesthetics and the surgeon immediately noticed the cardiac arrest and started resuscitative measures well-in time to save the patient's life. With all good intentions and team spirit, they transported the patient under manual ventilation (supporting respirations) and shifted the patient to Ganga Ram Hospital's ICU.

Sd/-

(Dr. Jagannatham)

15.11.1995"

It is on these medical papers produced by the prosecution, we have to decide whether the High Court was right in holding that criminal liability prima facie has arisen against the surgeon and he must face the trial. The legal position is almost firmly established that where a patient dies due to the negligent medical treatment of the doctor, the doctor can be made

liable in civil law for paying compensation and damages in tort and at the same time, if the degree of negligence is so gross and his act was reckless as to endanger the life of the patient, he would also be made criminally liable for offence under section 304A of IPC.

Section 304A of IPC reads thus :-

"304A. Causing death by negligence. \026 Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extent to two years, or with fine, or with both."

On behalf of the doctor learned counsel referred to section 80 and section 88 of the IPC to contend that in various kinds of medical treatment and surgical operation, likelihood of an accident or misfortune leading to death cannot be ruled out. A patient willingly takes such a risk. This is part of doctor patient relationship and mutual trust between them.

Section 80 and 88 read as under :-

"80. Accident in doing a lawful act. Nothing is an offence which 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.

88. Act not intended to cause death, done by consent in good faith for person's benefit. Nothing which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied, to suffer that harm, or to take the risk of that

harm."
Applying the laid down test for quashing or refusing to quash the criminal proceedings under section 482 of the Criminal Procedure Code, we have to find out whether from the complaint and the accompanying medical papers and by accepting the entire case alleged by the prosecution to be true, an order of conviction of the doctor for offence under section 304A of IPC can be passed.
The operation was performed on 18.4.1994 and the patient is alleged to have died on the same day. The post-mortem was performed after three days i.e. on 21.4.1994. According to the post-mortem report, the cause of death was : "blockage of respiratory passage by aspirated blood consequent upon surgically incised margin of nasal septum."
The medical experts constituting the Special Medical Board set up by the investigation have opined that "the blockage of air passage was due to aspiration of blood from the wound and it was not likely in the presence of cuffed endo-tracheal tube of proper size being introduced before the operation and remained in position." The team of experts also opined that 'presence of fluid and clotted blood in respiratory passage is likely, as it invariably occurs ante-mortem due to aspiration from operation site.' But they also opined that 'presence of fluid and clotted blood in the respiratory passage, as noted in the post-mortem report, due to trickling of decomposition bloody fluid and some clot present in the nostril from the site of incision in the nose, cannot be ruled out after the tube is taken out.'
Dr. Jagannatham, one of the members of the Special Medical Team constituted during investigation has, however, given separate opinion, the details of which we have quoted above. It seems to be to some extent in

favour of the accused surgeon. From the post-mortem report and the opinion of the three medical experts of the medical team specially constituted, the case of the prosecution laid against the surgeon is that there was negligence in 'not putting a cuffed endo-tracheal tube of proper size' and in a manner so as to prevent aspiration of blood blocking respiratory passage.
For fixing criminal liability on a doctor or surgeon, the standard of negligence required to be proved should be so high as can be described as "gross negligence" or recklessness". It is not merely lack of necessary care, attention and skill. The decision of the House of Lords in R. Vs. Adomako

(Supra) relied upon on behalf of the doctor elucidates the said legal position and contains following observations :-

"Thus a doctor cannot be held criminally responsible for patient's death unless his negligence or incompetence showed such disregard for life and safety of his patient as to amount to a crime against the State."

Thus, when a patient agrees to go for medical treatment or surgical operation, every careless act of the medical man cannot be termed as 'criminal'. It can be termed 'criminal' only when the medical man exhibits a gross lack of competence or inaction and wanton indifference to his patient's safety and which is found to have arisen from gross ignorance or gross negligence. Where a patient's death results merely from error of judgment or an accident, no criminal liability should be attached to it. Mere inadvertence or some degree of want of adequate care and caution might create civil liability but would not suffice to hold him criminally liable.

This approach of the courts in the matter of fixing criminal liability on the doctors, in the course of medical treatment given by them to their patients, is necessary so that the hazards of medical men in medical profession being exposed to civil liability, may not unreasonably extend to criminal liability and expose them to risk of landing themselves in prison for alleged criminal negligence.

For every mishap or death during medical treatment, the medical man cannot be proceeded against for punishment. Criminal prosecutions of doctors without adequate medical opinion pointing to their guilt would be doing great disservice to the community at large because if the courts were to impose criminal liability on hospitals and doctors for everything that goes wrong, the doctors would be more worried about their own safety than giving all best treatment to their patients. This would lead to shaking the mutual confidence between the doctor and patient. Every mishap or misfortune in the hospital or clinic of a doctor is not a gross act of negligence to try him for an offence of culpable negligence.

No doubt in the present case, the patient was a young man with no history of any heart ailment. The operation to be performed for nasal deformity was not so complicated or serious. He was not accompanied even by his own wife during the operation. From the medical opinions produced by the prosecution, the cause of death is stated to be 'not introducing a cuffed endo-tracheal tube of proper size as to prevent aspiration of blood from the wound in the respiratory passage'. This act attributed to the doctor, even if accepted to be true, can be described as negligent act as

there was lack of due care and precaution. For this act of negligence he
may be liable in tort but his carelessness or want of due attention and skill
cannot be described to be so reckless or grossly negligent as to make him criminally liable.
Between civil and criminal liability of a doctor causing death of his patient the court has a difficult task of weighing the degree of carelessness
and negligence alleged on the part of the doctor. For conviction of a doctor
for alleged criminal offence, the standard should be proof of recklessness
and deliberate wrong doing i.e. a higher degree of morally

blameworthy conduct.
To convict, therefore, a doctor, the prosecution has to come out with a case of high degree of negligence on the part of the doctor. Mere lack of
proper care, precaution and attention or inadvertence might create civil
liability but not a criminal one. The courts have, therefore, always insisted
in the case of alleged criminal offence against doctor causing death of his
patient during treatment, that the act complained against the doctor must
show negligence or rashness of such a higher degree as to indicate a mental state which can be described as totally apathetic towards the patient. Such gross negligence alone is punishable.
See the following concluding observations of the learned authors in their book on medical negligence under the title 'Errors, Medicine and the
Law' [by Alan Merry and Alexander McCall Smith at pg. 247-248]. The observations are apt on the subject and a useful guide to the courts in dealing with the doctors guilty of negligence leading to death of their patients :-
"Criminal punishment carries substantial moral overtones. The doctrine of strict liability allows for criminal conviction in the absence of moral
blameworthiness only in very limited circumstances. Conviction of any substantial criminal offence requires that the accused person should have acted with a morally blameworthy state of mind. Recklessness and deliberate wrong doing, levels four and five are classification of blame, are normally blameworthy but any conduct falling short of that should not be the subject of criminal liability. Common-law systems have traditionally only made negligence the subject of criminal sanction when the level of negligence has been high a standard traditionally described as gross negligence.
Blame is a powerful weapon. When used appropriately and according to morally defensible criteria, it has an indispensable role in human affairs. Its inappropriate use, however, distorts tolerant and constructive relations between people. Some of life's misfortunes are accidents for which nobody is morally responsible. Others are wrongs for which responsibility is diffuse. Yet others are instances of culpable
conduct, and constitute grounds for compensation and at times, for

punishment. Distinguishing between these various categories requires careful, morally sensitive and scientifically informed analysis."
After examining all the medical papers accompanying the complaint, we find that no case of recklessness or gross negligence has been made out against the doctor to compel him to face the trial for offence under section 304A of the IPC. As a result of the discussion aforesaid on the factual and legal aspect, we allow this appeal and by setting aside the impugned orders of the Magistrate and of the High Court, quash the criminal proceedings pending against the present doctor who is accused and appellant before us.

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION
CIVIL APPEAL NO. 3541 OF 2002
Martin F. D'Souza .. Appellant
-versus-
Mohd. Ishfaq .. Respondent
J U D G M E N T
MARKANDEY KATJU, J.
1. This appeal against the judgment of the National Consumer Disputes Redressal Commission, New Delhi dated 22.3.2002 has been filed under Section 23 of the Consumer Protection Act, 1986.
2. Heard learned counsel for the parties and perused the record.
3. The brief facts of the case are narrated below :
4. In March 1991, the respondent who was suffering from chronic renal failure was referred by the Director, Health Services to the Nanavati Hospital, Mumbai for the purpose of a kidney transplant.
5. On or about 24.4.1991, the respondent reached Nanavati Hospital, Bombay and was under the treatment of the appellant Doctor. At that stage, the respondent was undergoing haemodialysis twice a week on account of chronic renal failure. Investigations were underway to find a suitable donor. The respondent wanted to be operated by Dr. Sonawala alone who was out of India from 1.6.1991 to 1.7.1991.
6. On 20.5.1991, the respondent approached the appellant Doctor. At the time, the respondent, who was suffering from high fever, did not want to be

admitted to the Hospital despite the advice of the appellant. Hence, a broad spectrum antibiotic was prescribed to him.

7. From 20.5.1991 to 29.5.1991, the respondent attended the Haemodialysis Unit at Nanavati Hospital on three occasions. At that time, his fever remained between 101°-104°F. The appellant constantly requested the complainant to get admitted to hospital but the respondent refused.

8. On 29.5.1991 the respondent who had high fever of 104°F finally agreed to get admitted to hospital due to his serious condition.

9. On 30.5.1991 the respondent was investigated for renal package. The medical report showed high creatinine 13 mg., blood urea 180 mg. The Haemoglobin of the respondent was 4.3%. The following chart indicates the results of the study in comparison to the normal range :-

	Normal Range
S. Creatinine 13.0 mgs. %	0.7 – 1.5 mgs. %
Blood Urea 180 mgs. %	10-50 mgs. %
Haemoglobin 4.3 gms. %	11.5-13.5 gms. %

10. On 30.5.1991, the respondent was investigated for typhoid fever, which was negative. He was also investigated for ESR, which was expectedly high in view of renal failure and anemia infection. Urine analysis was also carried out which showed the presence of bacteria.

11. On 3.6.1991, the reports of the urine culture and sensitivity were received. The report showed severe urinary tract infection due to Klebsiella species (1 lac/ml.). The report also showed that the infection could be treated by Amikacin and Methenamine Mandelate and that the infection was resistant to other antibiotics. Methnamine Mandelate cannot be used in patients suffering from renal failure.

12. On 4.6.1991, the blood culture report of the respondent was received, which showed a serious infection of the blood stream (staphylococcus species).

13. On 5.6.1991, Amikacin injection was administered to the respondent for three days (from 5th to 7th June, 1991), since the urinary infection of the respondent was sensitive to Amikacin. Cap. Augmentin (375 mg.) was administered three times a day for the blood infection and the respondent was transfused one unit of blood during dialysis. Consequent upon the treatment, the temperature of the respondent rapidly subsided.

14. From 5.6.1991 to 8.6.1991, the respondent insisted on immediate kidney transplant even though the respondent had advised him that in view of his blood and urine infection no transplant could take place for six weeks.

15. On 8.6.1991, the respondent, despite the appellant's advice, got himself discharged from Nanavati Hospital. Since the respondent was suffering from blood and urinary infection and had refused to come for haemodialysis on alternate days, the appellant suggested Injection Amikacin (500 mg.) twice a day. Certain other drugs were also specified to be taken under the supervision of the appellant when he visited the Dialysis Unit.

16. On 11.6.1991, the respondent attended the Haemodialysis Unit and complained to the appellant that he had slight tinnitus (ringing in the ear). The appellant has alleged that he immediately told the respondent to stop taking the Amikacin and Augmentin and scored out the treatment on the discharge card. However, despite express instructions from the appellant, the respondent continued to take Amikacin till 17.6.1991. Thereafter, the appellant was not under the treatment of the appellant.

17. On 14.6.1991, 18.6.1991 and 20.6.1991 the respondent received haemodialysis at Nanavati Hospital and allegedly did not complain of deafness during this period.

18. On 25.6.1991, the respondent, on his own accord, was admitted to Prince Aly Khan Hospital, where he was also treated with antibiotics. The complainant allegedly did not complain of deafness during this period and conversed with doctors normally, as is evident from their evidence.

19. On 30.7.1991, the respondent was operated upon for transplant after he had ceased to be under the treatment of the appellant. On 13.8.1991, the respondent was discharged from Prince Aly Khan Hospital after his transplant. The respondent returned to Delhi on 14.8.1991, after discharge.

20. On 7.7.1992, the respondent filed a complaint before the National Consumer Disputes Redressal Commission, New Delhi (being Original Petition No.178 of 1992) claiming compensation of an amount of Rs.12,00,000/- as his hearing had been affected. The appellant filed his reply stating, inter alia, that

there was no material brought on record by the respondent to show any corelationship between the drugs prescribed and the state of his health. Rejoinder was filed by the respondent.

21. The National Consumer Disputes Redressal Commission (hereinafter referred to as `the Commission') passed an order on 6.10.1993 directing the nomination of an expert from the All India Institute of Medical Sciences, New Delhi (AIIMS) to examine the complaint and give an opinion. This was done in order to get an unbiased and neutral opinion.

22. AIIMS nominated Dr. P. Ghosh, and the report of Dr. P. Ghosh of the All India Institute of Medical Sciences was submitted before the Commission, after examining the respondent. Dr. Ghosh was of the opinion that the drug Amikacin was administered by the appellant as a life saving measure and was rightly used. It is submitted by the appellant that the said report further makes it clear that there has been no negligence on the part of the appellant.

23. Evidence was thereupon led before the Commission. Two affidavits by way of evidence were filed on behalf of the respondent, being that of his wife and himself. The witnesses for the respondent were :-

i) **The respondent Mohd. Ishfaq**
ii) **The wife of the respondent**
iii) **Dr. Ashok Sareen**
iv) **Dr. Vindu Amitabh**

24. On behalf of the appellant, six affidavits by way of evidence were filed. These were of the appellant himself, Dr. Danbar (a doctor attached to the Haemodialysis Department of Nanavati Hospital), Dr. Abhijit Joshi (a Resident Senior Houseman of Nanavati Hospital), Mrs. Mukta Kalekar (a Senior sister at Nanavati Hospital), Dr. Sonawala (the Urologist who referred the respondent to the appellant) and Dr. Ashique Ali Rawal (a Urologist attached to Prince Aly Khan Hospital). The witnesses for the appellant were:-

i) **The appellant-Dr. M.F. D'Souza**
ii) **Dr. Danbar**
iii) **Dr. Upadhyay**
iv) **Mrs. Mukta Kalekar**
v) **Dr. Ashique Ali Rawal**

25. The respondent also filed an opinion of the Chief of Nephrology at

Fairview General Hospital, Cleveland, Ohlo, which was heavily relied upon in the impugned judgment. The appellant has alleged that the said opinion was written without examining the respondent and, in any case, the appellant was not afforded an opportunity of cross-examining the person who gave the opinion.

26. The case of the respondent, in brief, is that the appellant was negligent in prescribing Amikacin to the respondent of 500 mg twice a day for 14 days as such dosage was excessive and caused hearing impairment. It is also the case of the respondent that the infection he was suffering from was not of a nature as to warrant administration of Amikacin to him.

27. The appellant submitted before the Commission that at the time of admission of the respondent on 29.5.1991 to the hospital, he had fever of 104°F and, after investigation, it was found that his serum creatinine level was 13 mg%, blood urea 180 mg% and Haemoglobin 4.3 mg. Amikacin was prescribed to him only after obtaining blood and urine culture reports on 3rd and 4th June, 1991, which showed the respondent resistant to other antibiotics. Even the witness of the respondent (Dr. Sareen) conceded that he would have prescribed Amikacin in the facts of the case. However, the Commission allowed the complaint of the respondent by way of the impugned order dated 9.4.2002 and awarded Rs.4 lakh with interest @ 12% from 1.8.1992 as well as Rs.3 lakh as compensation as well as Rs.5000/- as costs.

28. Before discussing the facts of the case, we would like to state the law regarding Medical Negligence in India.

29. Cases, both civil and criminal as well as in Consumer Fora, are often filed against medical practitioners and hospitals, complaining of medical negligence against doctors/hospitals/nursing homes and hence the latter naturally would like to know about their liability.

30. The general principles on this subject have been lucidly and elaborately explained in the three Judge Bench decision of this Court in Jacob Mathew vs. State of Punjab and Anr. (2005) 6 SCC 1. However, difficulties arise in the

application of those general principles to specific cases.
31. For instance, in para 41 of the aforesaid decision it was observed :
"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence is what the law requires."
32. Now what is reasonable and what is unreasonable is a matter on which even experts may disagree. Also, they may disagree on what is a high level of care and what is a low level of care.
33. To give another example, in paragraph 12 to 16 of Jacob Mathew's case (Supra), it has been stated that simple negligence may result only in civil liability, but gross negligence or recklessness may result in criminal liability as well. For civil liability only damages can be imposed by the Court but for criminal liability the Doctor can also be sent to jail (apart from damages which may be imposed on him in a civil suit or by the Consumer Fora). However, what is simple negligence and what is gross negligence may be a matter of dispute even among experts.
34. The law, like medicine, is an inexact science. One cannot predict with certainty an outcome of many cases. It depends on the particular facts and circumstances of the case, and also the personal notions of the Judge concerned who is hearing the case. However, the broad and general legal principles relating to medical negligence need to be understood.
35. Before dealing with these principles two things have to be kept in mind :
(1) Judges are not experts in medical science, rather they are lay men. This itself often makes it somewhat difficult for them to decide cases relating to medical negligence. Moreover, Judges have usually to rely on testimonies of other doctors which may not necessarily in all cases be objective, since like in all professions and services, doctors too sometimes have a tendency to support their own colleagues who are charged with medical negligence. The testimony may also be difficult to understand, particularly in complicated medical matters, for a layman in medical

matters like a Judge; and (2) A balance has to be struck in such cases. While doctors who cause death or agony due to medical negligence should certainly be penalized, it must also be remembered that like all professionals doctors too can make errors of judgment but if they are punished for this no doctor can practice his vocation with equanimity. Indiscriminate proceedings and decisions against doctors are counter productive and serve society no good. They inhibit the free exercise of judgment by a professional in a particular situation.

36. Keeping the above two notions in mind we may discuss the broad general principles relating to medical negligence.

General Principles Relating to Medical Negligence

37. As already stated above, the broad general principles of medical negligence have been laid down in the Supreme Court Judgment in Jacob Mathew vs. State of Punjab and Anr. (supra). However, these principles can be indicated briefly here :

38. The basic principle relating to medical negligence is known as the BOLAM Rule. This was laid down in the judgment of Justice McNair in Bolam vs. Friern Hospital Management Committee (1957) 1 WLR 582 as follows :

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

Bolam's test has been approved by the Supreme Court in Jacob Mathew's case.

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

"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge

would have prescribed different treatment or operated in a different way; nor is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men. Deviation from normal practice is not necessarily evidence of negligence. To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care."
(emphasis supplied)
40. Eckersley vs. Binnie (1988) 18 Con LR 1 summarized the Bolam test in the following words :
"From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members of his profession in the knowledge of new advances, discoveries and developments in his field. He should have such an awareness as an ordinarily competent would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of a polymath and prophet."
41. A medical practitioner is not liable to be held negligent simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another.
He would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field. For instance, he would be liable if he leaves a surgical gauze inside the patient after an operation vide Achutrao Haribhau Khodwa & others vs. State of Maharashtra & others, AIR 1996 SC 2377 or operates on the wrong part of the body, and he would be also criminally liable if he operates on someone for removing an organ for illegitimate trade.
42. There is a tendency to confuse a reasonable person with an error free

person. An error of judgment may or may not be negligent. It depends on the nature of the error.

43. It is not enough to show that there is a body of competent professional opinion which considers that the decision of the accused professional was a wrong decision, provided there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. As Lord Clyde stated in Hunter vs. Hanley 1955 SLT 213 :

"In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men…. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care…."

(emphasis supplied)

44. The standard of care has to be judged in the light of knowledge available at the time of the incident and not at the date of the trial. Also, where the charge of negligence is of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time.

45. The higher the acuteness in an emergency and the higher the complication, the more are the chances of error of judgment. At times, the professional is confronted with making a choice between the devil and the deep sea and has to choose the lesser evil. The doctor is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Which course is more appropriate to follow, would depend on the facts and circumstances of a given case but a doctor cannot be penalized if he adopts the former procedure, even if it results in a failure. The usual practice prevalent nowadays is to obtain the consent of the patient or of the person in-charge of the patient if the patient is not in a position to give consent before adopting a given procedure.

46. There may be a few cases where an exceptionally brilliant doctor

performs an operation or prescribes a treatment which has never been tried before to save the life of a patient when no known method of treatment is available. If the patient dies or suffers some serious harm, should the doctor be held liable? In our opinion he should not. Science advances by experimentation, but experiments sometime end in failure e.g. the operation on the Iranian twin sisters who were joined at the head since birth, or the first heart transplant by Dr. Barnard in South Africa. However, in such cases it is advisable for the doctor to explain the situation to the patient and take his written consent.

47. Simply because a patient has not favourably responded to a treatment given by a doctor or a surgery has failed, the doctor cannot be held straightway liable for medical negligence by applying the doctrine of *res ipsa loquitur*. No sensible professional would intentionally commit an act or omission which would result in harm or injury to the patient since the professional reputation of the professional would be at stake. A single failure may cost him dear in his lapse.

48. As observed by the Supreme Court in Jacob Mathew's case :

"A medical practitioner faced with an emergency ordinarily tries his best to redeem the patient out of his suffering. He does not gain anything by acting with negligence or by omitting to do an act. Obviously, therefore, it will be for the complainant to clearly make out a case of negligence before a medical practitioner is charged with or proceeded against criminally. A surgeon with shaky hands under fear of legal action cannot perform a successful operation and a quivering physician cannot administer the end-dose of medicine to his patient.

If the hands be trembling with the dangling fear of facing a criminal prosecution in the event of failure for whatever reason – whether attributable to himself or not, neither can a surgeon successfully wield his life-saving scalpel to perform an essential surgery, nor can a physician successfully administer the life-saving dose of medicine. Discretion being the better part of valour, a medical professional would feel better advised to leave a terminal patient to his own fate in the case of emergency where the chance of success may be 10% (or so), rather than taking the risk of making a last ditch effort towards saving the subject and facing a criminal

prosecution if his effort fails. Such timidity forced upon a doctor would be a disservice to society."

49. When a patient dies or suffers some mishap, there is a tendency to blame the doctor for this. Things have gone wrong and, therefore, somebody must be punished for it. However, it is well known that even the best professionals, what to say of the average professional, sometimes have failures. A lawyer cannot win every case in his professional career but surely he cannot be penalized for losing a case provided he appeared in it and made his submissions.

50. To fasten liability in criminal proceedings e.g. under Section 304A IPC the degree of negligence has to be higher than the negligence which is enough to fasten liability in civil proceedings. Thus for civil liability it may be enough for the complainant to prove that the doctor did not exercise reasonable care in accordance with the principles mentioned above, but for convicting a doctor in a criminal case, it must also be proved that this negligence was gross amounting to recklessness.

51. The difference between simple negligence and gross negligence has broadly been explained in paragraphs 12 to 16 of Jacob Mathew's case, though difficulties may arise in the application of the principle in particular cases. For instance, if a mop is left behind in the stomach of a patient while doing an operation, would it be simple negligence or gross negligence? If a scissors or sharp edged medical instrument is left in the patient's body while doing the operation would that make a difference from merely leaving a mop?

52. The professional is one who professes to have some special skill. A professional impliedly assures the person dealing with him (i) that he has the skill which he professes to possess, (ii) that skill shall be exercised with reasonable care and caution.

53. Judged by this standard, the professional may be held liable for negligence on the ground that he was not possessed of the requisite skill which he professes to have. Thus a doctor who has a qualification in Ayurvedic or

Homeopathic medicine will be liable if he prescribes Allopathic treatment which causes some harm vide Poonam Verma vs. Ashwin Patel & Ors. (1996) 4 SCC 332.

In Dr. Shiv Kumar Gautam vs. Alima, Revision Petition No.586 of 1999 decided on 10.10.2006, the National Consumer Commission held a homeopath liable for negligence for prescribing allopathic medicines and administering glucose drip and giving injections.

Protection to Doctors in Criminal Cases

54. In para 52 of Jacob Mathew's case the Supreme Court realizing that doctors have to be protected from frivolous complaints of medical negligence, has laid down certain rules in this connection :

(i) A private complaint should not be entertained unless the complainant has produced prima facie evidence before the court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor.

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

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

Precautions which Doctor/Hospitals/Nursing Homes should take :

(a) Current practices, infrastructure, paramedical and other staff, hygiene and sterility should be observed strictly. Thus, in Sarwat Ali Khan vs. Prof. R. Gogi and others Original Petition No.181 of 1997, decided on 18.7.2007 by the National Consumer Commission, the facts were that out of 52 cataract operations performed between 26th and 28th September, 1995 in an eye hospital 14 persons lost their vision in the operated eye. An enquiry revealed that in the Operation Theatre two autoclaves were not working properly. This equipment is absolutely necessary to carry out sterilization of instruments, cotton, pads, linen, etc., and the damage occurred because of its absence in working condition. The doctors were held liable.

(b) No prescription should ordinarily be given without actual examination. The tendency to give prescription over the telephone,

except in an acute emergency, should be avoided.
(c) A doctor should not merely go by the version of the patient regarding his symptoms, but should also make his own analysis including tests and investigations where necessary.
(d) A doctor should not experiment unless necessary and even then he should ordinarily get a written consent from the patient.
(e) An expert should be consulted in case of any doubt. Thus, in Smt. Indrani Bhattacharjee, Original Petition No.233 of 1996 decided by the National Consumer Commission on 9.8.2007, the patient was diagnosed as having `Mild Lateral Wall Eschemia'. The doctor prescribed medicine for gastro-entiritis, but he expired. It was held that the doctor was negligent as he should have advised consulting a Cardiologist in writing.
(f) Full record of the diagnosis, treatment, etc. should be maintained.
Application of the above mentioned general principles to particular cases : Decisions of the Court
55. In Pt. Parmanand Katara vs. Union of India & Others AIR 1989 SC 2039, the petitioner referred to a report published in the newspaper "The Hindustan Times" in which it was mentioned that a scooterist was knocked down by a speeding car. Seeing the profusely bleeding scooterist, a person who was on the road, picked up the injured and took him to the nearest hospital. The doctors refused to attend and told the man that he should take the patient to another hospital located 20 kilometers away authorized to handle medico-legal cases. The injured was then taken to that hospital but by the time he could reach, the victim succumbed to his injuries.
56. The Supreme Court referred to the Code of Medical Ethics drawn up with the approval of the Central Government under Section 33 of the Indian Council Medical Act and observed "Every doctor whether at a Government Hospital or otherwise has the professional obligation to extend his services for protecting life. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise cannot be sustained and, therefore, must give way."
57. The Supreme Court held that it is the duty of the doctor in an emergency to begin treatment of the patient and he should not await the arrival of the police or

to complete the legal formalities. The life of a person is far more important than legal formalities. This view is in accordance with the Hippocratic oath of doctors.

58. Although this decision has laid down that it is the duty of a doctor to attend to a patient who is brought to him in an emergency, it does not state what penalty will be imposed on a doctor who refuses to attend the said patient. Consequently it will depend on the fact and circumstances of the case. However, this case is important because nowadays health care has often become a business, as is mentioned in George Bernard Shaw's play "The Doctor's Dilemma". The medical profession is a noble profession and it should not be brought down to the level of a simple business or commerce. The truth of the matter, sadly, is that today in India many doctors (though not all) have become totally money-minded, and have forgotten their Hippocratic oath. Since most people in India are poor the consequence is that for them proper medical treatment is next to impossible, and hence they have to rely on quacks. This is a disgrace to a noble profession.

59. In Paschim Banga Khet Mazdoor Samity and others vs. State of West Bengal and Another AIR 1996 SC 2426, the Supreme Court held that the denial of emergency aid to the petitioner due to the non availability of bed in the Government Hospital amounts to the violation of the right to life under Article 21 of the Constitution. The Court went on to say that the Constitutional obligation imposed on the State by Article 21 cannot be abdicated on the ground of financial constraint.

60. In Md. Suleman Ansari (D.M.S.) vs. Shankar Bhandari (2005) 12 SCC 430 the respondent suffered a fracture of his hand. He went to the appellant who held himself out to be a qualified medical practitioner. The appellant bandaged the respondent's hand and prescribed certain medicines. He was ultimately taken to another doctor but by this time the damage to his hand was permanent. It was found that the appellant was not a qualified doctor to give treatment to the respondent. The Supreme Court had directed him to pay Rs.80,000 as compensation to the respondent.

61. In Surendra Chauhan vs. State of M.P. (2000) 4 SCC 110, the appellant

was having a degree of Bachelor of Medicine in Electrohomoeopathy from the Board of Electrohomoeopathy Systems of Medicines, Jabalpur (M.P.). He did not possess any recognized medical qualification as defined in the Indian Medical Council Act, 1956. Yet he performed an operation to terminate the three month pregnancy in a woman, who died in the clinic due to shock due to non application of anesthesia. The Supreme Court confirmed his sentence but reduced it to one and a half years rigorous imprisonment under Section 314/34 IPC and a fine of Rs.25000 payable to the mother of the deceased.

62. In State of Haryana and others vs. Raj Rani (2005) 7 SCC 22 it was held that if a child is born to a woman even after she had undergone a sterilization operation by a surgeon, the doctor was not liable because there cannot be a 100% certainty that no child will be born after a sterilization operation. The Court followed the earlier view of another three Judge Bench in State of Punjab vs. Shiv Ram & others (2005) 7 SCC 1. These decisions will be deemed to have overruled the two Judge Bench decision in State of Haryana and Others vs. Smt. Santra AIR 2000 SC 1888 in which it was held that if a child is born after the sterilization operation the surgeon will be liable for negligence.

63. In P.N. Rao vs. G. Jayaprakasu AIR 1990 AP 207, the plaintiff was a brilliant young boy who had passed the pre-University course securing 100% marks in Mathematics and 93.5% in physical sciences. He was also getting a monthly scholarship. He was offered a seat in B.E. Degree course in four Engineering Colleges. He had a minor ailment - chronic nasal discharge – for which his mother took him to a doctor for consultation who diagnosed the disease as Nasal Allergy and suggested operation for removal of tonsils. He was admitted in the Government General Hospital, Guntur and the operation was performed. He did not regain

consciousness even after three days and thereafter for another 15 days he was not able to speak coherently. When he was discharged from hospital, he could only utter a few words and could not read or write and lost all his knowledge and learning. His father took him to Vellore where he was examined by a Professor of Neuro Surgery and it was found that his brain had suffered due to cerebral anoxia, which was a result of improper induction of anaesthetics and failure to take immediate steps to reduce anaesthesia. The court after examining the witnesses including the Professor of Anaesthesiology held that defendants were clearly negligent in discharging their duties and the State Government was vicariously liable.

64. In Dr. Laxman Balkrishna Joshi vs. Dr. Trimbak Bapu Godbole and Another AIR 1969 SC 128, a patient had suffered from fracture of the femur. The accused doctor while putting the leg in plaster used manual traction and used excessive force for this purpose, with the help of three men, although such traction is never done under morphia alone but done under proper general anaesthesia. This gave a tremendous shock causing the death of the boy. On these facts the Supreme Court held that the doctor was liable to pay damages to the parents of the boy.

65. In Dr. Suresh Gupta vs. Government of N.C.T. of Delhi and another AIR 2004 SC 4091, the appellant was a doctor accused under Section 304A IPC for causing death of his patient. The operation performed by him was for removing his nasal deformity. The Magistrate who charged the appellant stated in his judgment that the appellant while conducting the operation for removal of the nasal deformity gave incision in a wrong part and due to that blood seeped into the respiratory passage and because of that the patient collapsed and died. The High Court upheld the order of the Magistrate observing that adequate care was not taken to prevent

seepage of blood resulting in asphyxia. The Supreme Court held that from the medical opinions adduced by the prosecution the cause of death was stated to be `not introducing a cuffed endotracheal tube of proper size as to prevent aspiration of blood from the wound in the respiratory passage.' The Supreme Court held that this act attributed to the doctor, even if accepted to be true, can be described as a negligent act as there was a lack of care and precaution. For this act of negligence he was held liable in a civil case but it cannot be described to be so reckless or grossly negligent as to make him liable in a criminal case. For conviction in a criminal case the negligence and rashness should be of such a high degree which can be described as totally apathetic towards the patient.

66. In Dr. Sr. Louie and Anr. vs. Smt. Kannolil Pathumma & Anr. the National Consumer Commission held that Dr. Louie showed herself as an M.D. although she was only M.D. Freiburg, a German Degree which is equivalent to an M.B.B.S. degree in India. She was guilty of negligence in treating a woman and her baby which died. There was vacuum slip, and the baby was delivered in an asphyxiated condition.

67. In Nihal Kaur vs. Director, P.G.I.M.S.R. (1996) CPJ 112 a patient died a day after surgery and the relatives found a pair of scissors utilized by the surgeon while collecting the last remains. The doctor was held liable and a compensation of Rs.1.20 lakhs was awarded by the State Consumer Forum, Chandigarh.

68. In Spring Medows Hospital & Another vs. Harjol Ahluwalia thr' K.S. Ahluwalia & Another (1998) CPJ 1, a minor child was admitted by his parents to a nursing home as he was suffering fever. The patient was admitted and the doctor diagnosed typhoid and gave medicines for typhoid fever. A nurse asked the father of the patient to get an injection Lariago which was administered by the nurse to the patient who immediately collapsed. The doctor was examined and testified that the

child suffered a cardiac arrest on account of the medicine having being injected which led to brain damage. The National Commission held that the cause of cardiac arrest was intravenous injection of Lariago of such a high dose. The doctor was negligent in performing his duty because instead of administering the injection himself he permitted the nurse to give the injection. There was clear dereliction of duty on the part of the nurse who was not even a qualified nurse and was not registered with any nursing council of any State. Both the doctor and nurse and the hospital were found liable and Rs.12.5 lakhs was awarded as compensation to the parents.

69. In Consumer Protection Council and Others vs. Dr. M. Sundaram and Another (1998) CPJ 3, the facts were that one Mrs. Rajalaxmi was admitted to a nursing home which diagnosed the ailment as Hodgkin's Lymphoma. She was administered Endoxan injection five doses in five days. She was referred to another doctor who was an ENT specialist, who after examination opined that no lymph glands were seen. A sample of her bone marrow was sent to an Oncologist who opined that the picture does not fit with Hodgkin's disease but the patient had megaloblastic anemia in the bone marrow. Subsequently she was discharged from the nursing home and was advised to visit CMC Vellore for treatment. The patient consulted another doctor who diagnosed the same as renal failure. The complainant alleged that the first doctor failed and neglected to refer the matter to a Cancer Specialist but wrongly diagnosed the ailment of the patient as Hodgkin's Lymphoma and had unnecessarily administered injection of Endoxan and because of the toxicity of that drug the kidney cells of the patient got destroyed resulting in renal failure for which she had to undergo kidney transplantation which led to her death. The National Commission, upholding the State Commission decision, held

that there was no negligence on the part of the doctor who had consulted a pathologist, and in the light of discussion with him and on inspection of some more slides of bone marrow specimens which also revealed the same finding, namely, existence of deposits of Hodgkin's Lymphoma, proceeded to administer the patient injections of Endoxan. It was held on the basis of medical opinion that any prudent consultant physician would not delay the commencement of chemotherapy where repeated examination of the bone marrow slides had yielded the report that the Hodgkin's deposits were present. Endoxan is a drug of choice in the treatment of Hodgkin's Lymphoma and there was no negligence on the part of the doctor.

70. In Sethuraman Subramaniam Iyer vs. Triveni Nursing Home and Another (1998) CPJ 110, the complainant's wife suffered from Sinusitis and was advised surgery by the doctor. She had suffered a massive heart attack while in the operation theatre. The State Commission found that necessary precautions and effective measures were taken to save the deceased and dismissed the complaint.

The State Commission relied on the affidavits of four doctors who opined that there was no negligence. The complainant had not given any expert evidence to support his allegation and in these circumstances it was held that no case was made out against the doctor.

71. In A. S. Mittal & Anr. vs. State of U.P. & Ors. JT 1989 (2) SC 419, 1989 (3) SCC 223 a free eye camp was organized for ophthalmic surgical treatment to patients. However, the eyes of several patients after operation were irreversibly damaged, owing to post-operative infection of the intra ocular cavities of the eyes, caused by normal saline used at the time of surgery. The Supreme Court directed the State Government to pay Rs.12,500/- as compensation to each victim as there was a clear negligence.

72. In Indian Medical Association vs. V.P. Shantha 1995(6) SCC 651 (vide

para 37) it has been held that the following acts are clearly due to negligence :
(i) Removal of the wrong limb;
(ii) Performance of an operation on the wrong patient;
(iii) Giving injection of a drug to which the patient is allergic without looking into the out-patient card containing the warning;
(iv) Use of wrong gas during the course of an anaesthetic, etc.
73. From the aforementioned principles and decisions relating to medical negligence, with which we agree, it is evident that doctors and nursing homes/hospitals need not be unduly worried about the performance of their functions. The law is a watchdog, and not a bloodhound, and as long as doctors do their duty with reasonable care they will not be held liable even if their treatment was unsuccessful.
74. However, every doctor should, for his own interest, carefully read the Code of Medical Ethics which is part of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 issued by the Medical Council of India under Section 20A read with Section 3(m) of the Indian Medical Council Act. 1956.
75. Having mentioned the principles and some decisions relating to medical negligence (with which we respectfully agree), we may now consider whether the impugned judgment of the Commission is sustainable. In our opinion the judgment of the Commission cannot be sustained and deserves to be set aside.
76. The basic principle relating to the law of medical negligence is the Bolam Rule which has been quoted above. The test in fixing negligence is the standard of the ordinary skilled doctor exercising and professing to have that special skill, but a doctor need not possess the highest expert skill. Considering the facts of the case we cannot hold that the appellant was guilty of medical negligence.
77. The facts of the case reveal that the respondent was suffering from

chronic renal failure and was undergoing haemodialysis twice a week on that account. He was suffering from high fever which remained between 101°-104°F. He refused to get admitted to hospital despite the advice of the appellant. The appellant prescribed antibiotics for him. The respondent was also suffering from severe urinary tract infection which could only be treated by Amikacin or Methenamine Mandelate. Since Methenamine Mandelate cannot be used in patients suffering from renal failure, Amikacin injection was administered to him.

78. A perusal of the complaint filed by the respondent before the National Commission shows that his main allegation is that he suffered hearing impairment due to the negligence of the appellant herein who allegedly prescribed overdose of Amikacin injections without caring about the critical condition of the respondent which did not warrant that much dose. The complainant (respondent herein) has alleged that due to this medical negligence the complainant has suffered mental torture and frustration and other signs of helplessness and is feeling totally handicapped, and his efficiency in office has got adversely affected. It may be mentioned that the respondent is working as Export Promotion Officer in the Ministry of Commerce, Udyog Bhawan, New Delhi.

79. The case of the appellant, however, is that the complainant was referred to the appellant by Dr. F. P. Soonawalla, the renowned Urologist of Bombay. The complainant had consulted Dr. F. P. Soonawalla who had referred the complainant to the appellant for routine Haemodialysis and pre-transplant treatment. In our opinion, the very fact that Dr. Soonawalla referred the complainant to the appellant is an indication that the appellant has a good reputation in his field, because Dr. Soonawalla is an eminent doctor of India of international repute, and he would not have ordinarily referred a patient to an incompetent doctor. This is one factor which goes in favour of the appellant, though of course it is not conclusive.

80. It appears that after the complainant was referred to the appellant by Dr.

Soonawalla he met the appellant for the first time on 24.4.1991 as an outdoor patient in the Haemodialysis Unit attached to Bulabhai Nanavati Hospital, Bombay.

After examining the complainant, the appellant found that the complainant was a patient of Chronic Renal Failure due to Bilateral Poly Cystic Kidneys. Hence the appellant suggested to the complainant to have Haemodialysis twice a week as an outdoor patient. The complainant was also investigated to find a suitable kidney donor.

81. The appellant has alleged in his written statement filed before the National Commission that the complainant was in a hurry to have a quick kidney transplant by Dr. Soonawalla and he was very obstinate, stubborn and shorttempered.

Dr. Soonawalla was out of India from 1.6.1991 to 1.7.1991. On 20.5.1991, the complainant approached the appellant with high fever of 101-103^{o}F, and the appellant suggested immediate admission of the complainant in the hospital for detailed investigation and treatment but the complainant refused to get himself admitted and refused to comply with the advice. Hence the appellant was obliged to put the complainant on a Broad Spectrum Antibiotic Ampoxim 500 mg four times a day and Tab. Crocin – SOS fever.

82. From 21.5.1991, the complainant attended the Haemodialysis unit of the hospital on three occasions and informed the appellant that the fever had not yet remitted. The appellant again advised the complainant to get admitted in hospital, but he refused the advice on account of his obstinacy.

83. On 29.5.1991, the complainant was in a serious condition having high fever of 104^{o}F. After much persuasion he finally agreed to be admitted for final investigation and got admitted in the hospital on 29.5.1991.

84. The complainant was investigated on 30.5.1991 and his report showed High Creatinine - 13 mg., Blood Urea – 180 mg and Haemoglobin 4.3% which was 5 days prior to the commencement of the injection Amikacin and not after the said injection.

85. In our opinion it is clear that the respondent already had high Blood Creatinine, Blood Urea and low Haemoglobin before the injection of Amikacin. He had also high fever which was on account of serious blood and urinary tract infection. The appellant was of the view that the respondent's infection could only be treated by injection of Amikacin, as Methenamine Mandelate could not be used due to his chronic renal failure. The respondent's report also established his resistance to all other antibiotics. Gastroscopy was done on 4.6.1991 and Amikacin was administered after test dosage only from 5.6.1991. Amikacin was administered on 5th, 6th and 7th June, 1991 and at this stage he did not complain of any side effects and his temperature subsided rapidly. On 5.6.1991, he was administered Cap. Augmentin 375 mg three times a day for his serious Blood Infection and he was also transferred one Unit of Blood during dialysis and his temperature subsided rapidly and he felt much better.

86. The appellant advised the respondent in view of his blood infection that he should not get transplanted for six weeks, but the complainant/respondent insisted on getting the transplant although he was not medically in fit condition. Hence the appellant advised the respondent to further stay in the hospital for some time, but the respondent did not agree and he started shouting at the top of his voice and insisted to be discharged from the hospital on his own on 8.6.1991 at 9 a.m..

87. In view of his insistence the respondent was discharged from the hospital on his own on 8.6.1991 at 9 a.m.. The appellant suggested alternate day Haemodialysis but the respondent refused saying that he was staying too far away and could not come three times a week for Haemodialysis. In this situation, the appellant was left with no choice but to suggest Injection Amikacin (500 mg) twice a

day in view of the respondent's infection and delicate condition and his refusal to visit the Haemodialysis facility on alternate dates. The appellant also suggested the following drugs under the supervision of the doctor when he would visit the dialysis unit:

"1. Injection Amikacin 500 mg twice a day x 10 days for urinary tract infection.
2. Cap. Augmentine 375 mg 3 times a day for 6 weeks for blood infection
3. Cap. Becosule tab daily
4. Tab. Folvite 1 tab. Daily
5. Syrup Alludux
6. Injection Engrex once a month for 2 months
7. Cap. Bantes 100 mg twice a day"

88. It appears that the respondent attended the Haemodyalsis unit where he met the appellant on 11th, 14th, 18th and 20th June, 1991. Thereafter the respondent did not come to the hospital.

89. On 11.6.1991 the respondent complained to the appellant of slight tinnitus or ringing in the ear. The appellant immediately reviewed the treatment on the discharge card in possession of the respondent and asked the said respondent and also asked his attendant i.e. his wife to stop Injection Amikacin and Cap. Augmantine verbally, and also marked 'X' on the discharge card in his own hand writing on 11.6.1991 i.e. 3 days after discharge. Hence, as per direction of the appellant the respondent should have stopped receiving Injection Amikacin after 10.6.1991, but on his own he kept on taking Amikacin Injections. The Discharge Card as per the respondent's complaint clearly shows that the said injection had been 'X' crossed, and he was directed not to take the said injection from 11.6.1991 i.e. on his very first complaint when he made mention of ringing in the ears or tinnitus.

90. On perusal of the Xerox copies of the papers of the Cash Memo supplied by the respondent as per annexure '4' it is in our opinion evident that the

respondent continued to take the medicine against the advice of the appellant, and had unilaterally been getting injected as late as 17.6.1991, i.e. 7 days after he had been instructed verbally and in writing in the presence of his attendant i.e. his wife and staff members of the said hospital to stop Injection Amikacin/Cap. Augmantine because of tinnitus as early as on 11.6.1991.

91. On 19.6.1991 a relative of the respondent who identified himself on the phone as one Mr. Khan from Byculla rang up and stated that the said respondent was once again running high fever. The appellant once again immediately advised him urgent admission to the said hospital which the respondent refused to comply and said that he would go elsewhere.

92. From the above facts it is evident that the appellant was not to blame in any way and it was the non-cooperative attitude of the respondent, and his continuing with the Amikacin injection even after 11.6.1991 which was the cause of his ailment, i.e. the impairment of his hearing. A patient who does not listen to his doctor's advice often has to face the adverse consequences.

93. It is evident from the fact that the respondent was already seriously ill before he met the appellant. There is nothing to show from the evidence that the appellant was in any way negligent, rather it appears that the appellant did his best to give good treatment to the respondent to save his life but the respondent himself did not cooperate.

94. Several doctors have been examined by the National Commission and we have read their evidence which is on record. Apart from that, there is also the opinion of Prof. P. Ghosh of All India Institute of Medical Sciences who had been nominated by AIIMS as requested by the Commission, which is also on record. It has been stated by Dr. Ghosh that many factors in the case of renal diseases may cause hearing loss. Prof. Ghosh has stated that it is impossible to foretell about the sensitivity of a patient to a drug, thereby making it difficult to assess the

contributions towards toxicity by the other factors involved. Hearing loss in renal patients is a complex problem which is a result of many adverse and unrelated factors. Generally, the state of hearing of a renal patient at any time is more likely to be the result of a multifactorial effect than the response to a single agent.

95. Prof Ghosh has no doubt mentioned that concomitant use of Aminoglycoside antibiotics (e.g. Amikacin) and loop diuretic may lead to summation and potentiation of ototoxic effect, and the patient has a higher risk factor of hearing impairment if there is a higher dose of Amikacin. However, he has stated that such gross impairment of the balancing function has perhaps been wrought by a combination of factors.

96. Prof Ghosh has also opined that the Amikacin dose of 500 mg twice a day for 14 days prescribed by the doctor was a life saving measure and the appellant did not have any option but to take this step. Life is more important than saving the function of the ear. Prof Ghosh was of the view that antibiotics was rightly given on the report of the sensitivity test which showed that the organisms were sensitive to Amikacin. Hence the antibiotic, was not blindly used on a speculation or as a clinical experiment.

97. Prof Ghosh mentioned that in the literature on Amikacin it has been mentioned that in a life threatening infection adult dosage may be increased to 500 mg every eight hours but should not be administered for longer than 10 days.

98. In view of the opinion of Prof Ghosh, who is an expert of the All India Institute of Medical Sciences, we are clearly of the view that the appellant was not guilty of medical negligence and rather wanted to save the life of the respondent.

The appellant was faced with a situation where not only was there kidney failure of the patient, but also urinary tract infection and blood infection. In this grave situation threatening the life of the patient the appellant had to take drastic steps.

Even if he prescribed Amikacin for a longer period than is normally done, he obviously did it to save the life of the respondent.

99. We have also seen the evidence of other doctors as well as the affidavits filed before the National Commission. No doubt some of the doctors who have deposed in this case have given different opinions, but in cases relating to allegations of medical negligence this Court has to exercise great caution.

100. Dr. Ashok Sareen who is MD in medicine and trained in Nephrology has in his evidence stated that for Kidney failure patients one has to be very careful with the drug Amikacin. He stated that he uses the drug only when other antibiotics have failed or cannot be used. It should be used with wide intervals and only when absolutely necessary and when no other drug is available. When asked whether Amikacin should be given to a patient with 10 days stretch, as was prescribed by the appellant in this case, Dr. Sareen replied that it was difficult to give an answer to that question because it depends entirely on the treating physician. Dr. Sareen has admitted that giving Amikacin injection twice a day for 14 days can cause nerve deafness which means losing one's hearing. No doubt, Dr. Sareen in his crossexamination stated that he would have prescribed the dose given to the respondent differently but he has not stated what would be the dose he would have prescribed.

101. We have also perused the evidence of Dr. Vindu Amitabh, who is a MD in medicine in Safdarjung hospital and looking after Nephrology also. He has stated that normally Amikacin is given for 5 to 7 days twice daily. However, he has also stated that in severe circumstances it can be given for a longer period but if the patient is developing complications then the doses should be stopped immediately.
If there is no substitute for it then Amikacin should be given in a very guarded dose.
He has admitted that Amikacin can lead to deafness.

102. In the affidavit of Dr. Raval of the Bombay Indian Inhabitant, who has been practicing in Urology for several years it is stated that the respondent had undergone a kidney transplant operation under Dr. Raval's supervision on 30th July

1991 at the Prince Alikhan Hospital, Bombay and he was discharged on 13th August,
1991. Dr. Raval has stated in his affidavit that during the time the respondent was
under his care he had a free conversation in English and Urdu without the aid of
interpreter and he did not complain of suffering any hearing problem until he was
discharged in the middle of August 1991. An affidavit to the same effect has been
given by Dr. Kirti L. Upadhyaya, of Bombay Indian Inhabitant, who is also a Nephrologist. He stated that the respondent did not complain of any hearing
problem to him also.
103. An affidavit has also been filed by Dr. Sharad M. Sheth, of Bombay Indian Inhabitant who is also MD qualified in Nephrology. He also stated in paragraph 3 of his affidavit as follows:-
"I state that in the circumstances of the case when Klebsiella Organism was found resistant to all powerful drugs inclusive of Augmentin with the exception of Amikacin any nephrologist of a reasonable standard of proficiency would have prescribed "Amikacin" drug in measured doses as a life saving drug despite the well established fact that this drug might cause 'tinnitus' or partial hearing impairment which is reversible, to almost complete extent in most of the cases after discontinuation of the drug as soon as any of the above symptoms makes its appearance. I state that in this situation, 'Amikacin' could not have been avoided if the danger to the life of the patient had to be thwarted. The diagnosis of Dr. M.F. D'Souza and the line of treatment adopted and administered to the said Shri Mohd. Ishaq, who was suffering from a renal failure in addition to the above specific infections appears to be correct."
104. The appellant has also filed his own affidavit before the National Consumer Commission which we have perused. We have also seen the affidavit of
Dr. Ashok L. Kirpalani of Lady Ratan Tata Medical Centre, Bombay, who is MD in
Nephrology. He stated that the medicine prescribed by the appellant was absolutely
right in the circumstances in view of the fact, that the patient was suffering serious
life threatening infection.
105 We may also refer to the affidavit of Mrs. Mukta Kolekar of Bombay Indian Inhabitant, who is a Senior Sister attached to the hospital. She has stated

in her affidavit as follows :-
"I know Dr. Martin F.D'Souza who is a Nephrologist and who is attached to the said hospital since 1984. I say that I know Mr. Mohd. Ishaq. I distinctly remember him, as very few patients are as ill-tempered arrogant and obstinate like him. The said Mohd. Ishaq came to the said hospital as an outdoor as well as indoor patient for Haemodialysis on a number of occasions commencing from the month of April, 14th 1991 till 20th June, 1991 till 8th June, 1991 until suo moto he left the hospital. I say that on 11th June,1991 the said Mohd. Ishaq came to the hospital for the purpose of Haemodialysis. He had come of his own and he had no problem either in walking or in hearing. Nothing abnormal was found in him. However, during Haemodialysis, he complained to the Doctor of ringing in the ears and thereupon Dr. Martin F.D'Souza called for the Discharge Card of the said Mohd. Ishaq and verified the medicine and injections which were prescribed and on verification, Dr. Martin F.D'Souza immediately deleted injection Amikacine and Cap. Augmentin and put a cross against the prescription of the said injection, and immediately gave instructions to me as well as to the other staff members not to give that injection at all, and also told the said Mohd. Ishaq and his wife who had accompanied him, not to take or get administered the said injection.
I say that after 11th June, 1991, the said Mohd. Ishaq came to the hospital as an outdoor patient on 14th June, 17th June and 20th June, 1991 and did not make any complaint of any nature whatsoever with regard to his hearing faculties. On the contrary, he used to have conversation and used to respond to the same as an ordinary man. The said Mohd. Ishaq used to come to hospital on his own without the assistance or help of anybody and after the dialysis also he used to go on his own. Thus, until 20th June, 1991, the said Mohd. Ishaq had no problems either in hearing or in movement of the limbs or parts of his body or in lifting parts of his body or in walking."
106. From these deposition and affidavits it cannot be said that the appellant was negligent. In fact most of the doctors who have deposed or given their affidavits before the Commission have stated that the appellant was not negligent.
107. In his written statement filed before the National Commission the appellant has stated in paragraph 9 (q-r) as follows :
"(q) On the 11th June,1991 the Complainant complained to Opposite Party of slight tinnitus or ringing in the ear. Opposite Party immediately reviewed the treatment on the discharge card in possession of the Complainant and asked the

said Complainant and also made his attendant i.e. his wife to understand and asked her also to stop Injection Amikacin and Cap. Augmentin verbally as well as marked 'X' on the discharge card in his own hand writing i.e. on 11th June, 1991 i.e. 3 days after discharge. Therefore, as per direction Opposite Party Complainant could have taken or received Injection Amikacin only upto 10th June, 1991 when he showed the very first and Preliminary side effect of Injection Amikacin. Discharge Card as per the Complainant's Complaint Annexure '3'speaks clearly that the said Injection has been 'X' crossed and he was directed not to take the said Injection from 11th June, 1991 i.e. on his very first complaint he made of ringing in the ears, or tinnitus.

(r) On perusal of the Xerox copies of the papers of the Cash Memo supplied by the Complainant as per Annexure '4' it is evident that the Complainant against the advice of the Opposite Party and in breach of assurances, high handedly and unilaterally had been getting injected as late as 17th June, 1991 i.e. 7 days after he had been instructed verbally and in writing in the presence of his attendant i.e. his wife and staff members of the said hospital to stop Injection Amikacin/Cap. Augmentin because of tinnitus as early as 11th June, 1991"

108. We see no reason to disbelieve the above allegations of the appellant that on 11.6.1991 he had asked the respondent to stop taking Amikacin injections, and in fact this version is corroborated by the testimony of the Senior Sister Mukta Kolekar in her affidavit, relevant part of which has been quoted above. Hence, it was the respondent himself who is to blame for having continued Amikacin after 11.6.1991against the advice of the appellant.

109. Moreover, in the statement of Dr. Ghosh before the National Consumer Dispute Redressal Commission it has been stated that it is by no means established that Amikacin alone can cause deafness. Dr. Ghosh stated that there are 8 factors that can cause loss of hearing. Moreover, there are conflicting versions about the deafness of the respondent. While the respondent stated that he became deaf in June 1991, most of the Doctors who filed affidavits before the Commission have stated that they freely conversed with him in several meetings much after 21st June

and in fact up to the middle of August 1991.

110. The National Commission had sought the assistance of AIIMS to give a report about the allegations of medical negligence against the appellant. AIIMS had appointed Dr. Ghosh to investigate the case and submit a report and Dr. Ghosh submitted a report in favour of appellant. Surprisingly, the Commission has not placed much reliance on the report of Dr. Ghosh, although he is an outstanding ENT specialist of international repute.

111. We have carefully perused the judgment of the National Commission and we regret that we are unable to concur with the views expressed therein. The Commission, which consists of laymen in the field of medicine, has sought to substitute its own views over that of medical experts, and has practically acted as super-specialists in medicine. Moreover, it has practically brushed aside the evidence of Dr. Ghosh, whose opinion was sought on its own direction, as well as the affidavits of several other doctors (referred to above) who have stated that the appellant acted correctly in the situation he was faced.

112. The Commission should have realized that different doctors have different approaches, for instance, some have more radical while some have more conservative approaches. All doctors cannot be fitted into a straight-jacketed formula, and cannot be penalized for departing from that formula.

113. While this Court has no sympathy for doctors who are negligent, it must also be said that frivolous complaints against doctors have increased by leaps and bounds in our country particularly after the medical profession was placed within the purview of the Consumer Protection Act. To give an example, earlier when a patient who had a symptom of having a heart attack would come to a doctor, the doctor would immediately inject him with Morphia or Pethidine injection before sending him to the Cardiac Care Unit (CCU) because in cases of heart attack time is

the essence of the matter. However, in some cases the patient died before he reached the hospital. After the medical profession was brought under the Consumer Protection Act vide Indian Medical Association vs. V.P. Shantha 1995 (6) SCC 651 doctors who administer the Morphia or Pethidine injection are often blamed and cases of medical negligence are filed against them. The result is that many doctors have stopped giving (even as family physicians) Morphia or Pethidine injection even in emergencies despite the fact that from the symptoms the doctor honestly thought that the patient was having a heart attack. This was out of fear that if the patient died the doctor would have to face legal proceedings.

114. Similarly in cases of head injuries (which are very common in road side accidents in Delhi and other cities) earlier the doctor who was first approached would started giving first aid and apply stitches to stop the bleeding. However, now what is often seen is that doctors out of fear of facing legal proceedings do not give first aid to the patient, and instead tell him to proceed to the hospital by which time the patient may develop other complications.

115. Hence Courts/Consumer Fora should keep the above factors in mind when deciding cases related to medical negligence, and not take a view which would be in fact a disservice to the public. The decision of this Court in Indian Medical Association vs. V.P. Shantha (Supra) should not be understood to mean that doctors should be harassed merely because their treatment was unsuccessful or caused some mishap which was not necessarily due to negligence. In fact in the aforesaid decision it has been observed (vide para 22) :-

"In the matter of professional liability professions differ from other occupations for the reason that professions operate in spheres where success cannot be achieved in every case and very often success or failure depends upon factors beyond the professional man's control."……

116. It may be mentioned that the All India Institute of Sciences has been

doing outstanding research in Stem Cell Therapy for the last eight years or so for treating patients suffering from paralysis, terminal cardiac condition, parkinsonism, etc, though not yet with very notable success. This does not mean that the work of Stem Cell Therapy should stop, otherwise science cannot progress.

117. We, therefore, direct that whenever a complaint is received against a doctor or hospital by the Consumer Fora (whether District, State or National) or by the Criminal Court then before issuing notice to the doctor or hospital against whom the complaint was made the Consumer Forum or Criminal Court should first refer the matter to a competent doctor or committee of doctors, specialized in the field relating to which the medical negligence is attributed, and only after that doctor or committee reports that there is a prima facie case of medical negligence should notice be then issued to the concerned doctor/hospital. This is necessary to avoid harassment to doctors who may not be ultimately found to be negligent. We further warn the police officials not to arrest or harass doctors unless the facts clearly come within the parameters laid down in Jacob Mathew's case (supra), otherwise the policemen will themselves have to face legal action.

118. In the present case the appellant was faced with an extremely serious situation. Had the appellant been only suffering from renal failure it is possible that a view could be taken that the dose prescribed for the appellant was excessive.

However, the respondent was not only suffering from renal failure but he was also suffering from urinary tract infection and also blood infection i.e Septicaemia which is blood poisoning caused by bacteria or a toxin. He had also extremely high urea.

In this extremely serious situation, the appellant had naturally to take a drastic measure to attempt to save the life of the respondent. The situation was aggravated by the non-cooperation of the respondent who seems to be of an assertive nature

as deposed by the witnesses. Extraordinary situations require extraordinary remedies. Even assuming that such a high dose of Amikacin would ordinarily lead to hearing impairment, the appellant was faced with a situation between the devil and the deep sea. If he chose to save the life of the patient rather than his hearing surely he cannot faulted.

119. In the present case the blood urea of the respondent was found to be 180 mgs.% whereas normally it should not exceed 10-50 mgs.%. This shows that very serious infection in the kidney of the respondent was taking place which required drastic measures.

120. The allegation against the appellant is that he gave overdose of the antibiotic. In this connection it may be mentioned that antibiotics are usually given for a minimum of five days, but there is no upper limit to the number of days for which they should continue, and it all depends on the condition of the patient.

Giving lesser dose of antibiotic may create other complications because it can cause resistance in the bacteria to the drug, and then it will be more difficult to treat.

121. As regards the impairment of hearing of the respondent it may be mentioned that there is no known antibiotic drug which has no side effect. Hence merely because there was impairment in the hearing of the respondent that does not mean that the appellant was negligent. The appellant was desperately trying to save the life of the respondent, which he succeeded in doing. Life is surely more important than side effects.

122. For example many Anti Tubercular drugs (e.g. Streptomycin) can cause impairment of hearing. Does this mean that TB patients should be allowed to die and not be given the Anti Tubercular drug because it impairs the hearing? Surely the answer will be in the negative.

123. The courts and Consumer Fora are not experts in medical science, and must not substitute their own views over that of specialists. It is true that the

medical profession has to an extent become commercialized and there are many doctors who depart from their Hippocratic oath for their selfish ends of making money. However, the entire medical fraternity cannot be blamed or branded as lacking in integrity or competence just because of some bad apples.

124. It must be remembered that sometimes despite their best efforts the treatment of a doctor fails. For instance, sometimes despite the best effort of a surgeon, the patient dies. That does not mean that the doctor or the surgeon must be held to be guilty of medical negligence, unless there is some strong evidence to suggest that he is.

125. On the facts of this particular case, we are of the opinion that the appellant was not guilty of medical negligence. Resultantly, the appeal is allowed; the impugned judgment and order of the National Commission is set aside. No costs.

.....J.
[MARKANDEY KATJU]

.....J.
[R.M. LODHA]

New Delhi,
February 17, 2009.