

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION
WRIT PETITION (CIVIL) NO. 373 OF 2022
[UNDER ARTICLE 32 OF THE CONSTITUTION OF INDIA]
PUBLIC INTEREST LITIGATION

IN THE MATTER OF:

Dr.Suneet Kumar Upadhyaya & Ors.

Petitioners

Versus

Union of India &Ors.

Respondents

with

I.A NO. _____ OF 2022
APPLICATION FOR EXEMPTION FROM FILING OFFICIAL
TRANSLATIONS

with

I.A NO. _____ OF 2022
APPLICATION FOR SEEKING EXEMPTION FROM FILING
DULY NOTARISED AFFIDAVITS

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ADVOCATE FOR THE PETITIONER : POOJA DHAR

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Mentioning on dated.22.07.2022
Writ Petition(C) No.373 of 2022
Dr. Suneet Kumar Upadhyaya & Ors. Vs U.O.I & Ors

LISTING PROFORMA
IN THE SUPREME COURT OF INDIA

Section: PIL

	Central Act:	Constitution of India
	Section	Article 32
	Central Rule (Title)	NA
	Rule No.(s)	NA
	State Act (Title):	NA
	Section	NA
	State Rules (Title)	NA
	Rule No(s):	NA
	Impugned Interim Order	NA
	Impugned Final order/decreed:	NA
	High Court:	NA
	Name of Judges	NA
	Tribunal/Authority:	NA
1.	Name of Matter:	Civil
2.	(a) Petitioners /appellant No.1 (b)e-mail ID (c) Mobile Phone Number	Dr. Suneet Kumar Upadhyaya & Ors. NA N.A
3.	(a) Respondent No.1 (b)e-mail ID (c) Mobile Phone Number	Union of India & Ors. NA NA
4	(a) Main category classification: (b) Sub Classification:	08 PIL Matters 0812, Others
5.	Not to be listed before:	NA

6.	a) Similar disposed of matter with citation, if any & Case Details b) Similar Pending matter with the case details.	No Similar disposed matter No Similar Pending matter
7.	Criminal Matters:	NA
	(a) Whether accused/convict has surrender (b) Complaint No./Date (c) Police Station (d) Sentence awarded (e) Sentence undergone	N.A NA
8.	Land Acquisition Matters:	N.A
	(a) Date of Section 4 notification (b) Date of Section 6 notification (c) Date of Section 17 notification	NA
9.	Tax Matter: State the tax effect	NA
10	Special Category	NA
11	Vehicle number (in case of Motor Accident Claim matters):	NA

FILED ON: 22.07.2022

filed by: -



POOJA ADHAR

Advocate for the Petitioners

Email:- officeofpoojadhar@gmail.com

CC-2048

SYNOPSIS

B

The instances of violence and frivolous prosecutions against registered medical practitioners and healthcare service providers have increased during the unprecedented times of Covid-19 pandemic. These instances usually arise out of the death of patients where the families of the patients try to harass the registered medical practitioners and healthcare service providers out of frustration, some on account of extortion of illegal money and some due to other reasons.

The Petitioner No. 1 has personally suffered on account of death of his wife due to suicide. As it happened, the Petitioner No. 1 and his wife Dr. Archana Sharma on 27.03.2022 got a patient namely Asha Bairwa who expected her third child. The patient in her second pregnancy gave birth to twins at the hospital of Petitioner No. 1 and his wife. This pregnancy was tough for the patient as she suffered Post-partum Hemorrhage (PPH) after giving birth and she could not be saved despite all possible efforts by the wife of Petitioner No. 1.

A few hours after the death of the patient, crowd gathered outside the hospital and protested against the Petitioner No. 1 and his wife. Later an FIR was registered against the Petitioner and his wife u/s 302 without any expert opinion and merely as a knee jerk reaction to public sentiments. The wife of the

Petitioner No. 1 could not tackle the pressure of the defamatory publications, threats, and frivolous prosecutions and committed suicide on 29.03.2022.

As mentioned in the following pages, there have been plethora of cases of violence and frivolous criminal prosecutions against the healthcare service providers, most of which are devoid of any merit and done out of frustration, solely to harass healthcare service providers.

Petitioner No. 2 and 3 are both medical practitioners with decades of standing in the medical profession and are very well known in their respective branches of medicine. Over these years, both Petitioner No. 2 and 3 have been witnessing such instances of violence and frivolous prosecution against their fellow medical practitioners and are deeply affected by the plights of entire medical fraternity.

Despite categorical guidelines issued by this Hon'ble Court in *Jacob Mathew v. State of Punjab* 2005 6 SCC 1 and *Kusum Sharma v. Batra Hospital*, [2010 3 SCC 480], it is disappointing to see that there is no compliance of these guidelines by the Respondents.

This Public Interest Petition under Article 32 of the Constitution of India seeks to bring the kind attention of this Hon'ble Court to the plight of registered medical practitioners and healthcare service providers, who are facing hostile

actions at the hands of the public. This petition prays for issuance of guidelines that police officers should be sensitized against indiscriminate registration of criminal complaints against all healthcare service providers. Further, this Petition is also praying for issuance of appropriate directions pertaining to the cases of violence against healthcare service providers including directions to the Respondents for providing safety to healthcare service providers at the workplace along with directions to compensate healthcare service providers and their families in the event of violence and frivolous prosecutions.

This petition prays the aforementioned on the following grounds-

- It is extreme importance for the medical fraternity that it discharges its duty of serving people without any fear of violence and criminal prosecution. It is appalling that despite existing guidelines and observations issued by this Hon'ble Court in *Jacob Mathew*, *Kusum Sharma* and other cases, there is no effort made by the respective State Governments to sensitize the police force to provide protection to doctors and refrain from filing initiating frivolous and baseless prosecutions against the medical professionals.
- The complexity of medical science and health problems is tough for a police officer to understand without proper knowledge, the lack of such knowledge makes a police officer unqualified to carry out prosecution of a healthcare service providers. Such cases against the healthcare service providers

required expert opinion before a criminal case is instituted; a police officer cannot prosecute healthcare service providers merely because of pressure from public.

- A doctor treats a patient with proper consent of the patient or his family, in that case, the death of a patient is not a result of *mensrea* of the doctor. No act of a healthcare service provider is intended to cause harm to the patient.
- All the government and even private hospitals lack proper measures of safety and security of healthcare service providers against cases of violence arising out of any mishap or deaths of patients.
- Violence and criminal implications against the healthcare service providers not only result in loss of life / health but also results in a huge loss of reputation. Therefore, it becomes pertinent that the healthcare service providers and their families are compensated in the event of violence, frivolous prosecutions.
- These continuing instances of violence and frivolous prosecution against healthcare service providers have given rise to erosion of faith from the medical system of the country. There has also been a lack of mutual trust between the doctors and the patients. There is an urgent need that the faith of the public as well as that of the healthcare service providers be restored.

LIST OF DATES

Date	Particulars
04.08.2004	This Hon'ble Court delivered its decision in <i>Suresh Gupta v. Govt. of NCT of Delhi</i> [2004 6 SCC 422] wherein it emphasized on the importance of adequate medical opinion before criminal prosecution of a doctor.
05.08.2005	This Hon'ble Court delivered its decision in <i>Jacob Mathew v. State of Punjab</i> [2005 6 SCC 1] wherein it laid down guidelines for prosecution of healthcare service providers, it also held that the treatment by a doctor falls under Section 88 of IPC since it is not intended to cause death.
10.02.2010	This Hon'ble Court delivered its decision in <i>Kusum Sharma v. Batra Hospital</i> , [2010 3 SCC 480] wherein it laid down categorical principles pertaining to criminal prosecution of medical professionals.

August- 2018	Study by Indian Medical Association (IMA) published in the Indian Journal of Medical Research which discovered that 75 per cent of doctors in India have faced violence at some point of time in their life.
02.09.2019	The Ministry of Health & Family Welfare notified the draft of ‘The Healthcare Service Personnel and Clinical Establishments (Prohibition of violence and damage to property) Bill, 2019’ for objections and suggestions from public.
April-2020	The Epidemic Diseases (Amendment) Act, 2020 was brought to force.
29.07.2020	Dr Dinesh Varma, head of Alfa Speciality Hospital was grievously stabbed in several places by the relative of a COVID 19 patient who succumbed to the disease.
23.04.2021	Family of a 72 year old covid-19 patient who succumbed to the it, attacked the resident doctors at Swaroop Rani Hospital in Prayagraj.

24.05.2021	Son of a COVID-19 patient assaulted a doctor in Ballari's VIMS Hospital.
29.05.2021	Karnataka based Dr. Deepak was assaulted by four men who were family members of a 6 year old child who died of Dengue complications.
01.06.2021	Dr. Seuj Kumar Senapati was brutally assaulted by more than 30 people at the Udai Covid Care Centre in Hojai District of Assam
01.06.2021	Indian Medical Association wrote to the Home Minister of India drawing his attention to cases of violence and frivolous prosecution against healthcare service providers and demanded a strong and comprehensive law.
29.09.2021	National Medical Commission wrote to the Ministry of Health & Family Welfare wherein it recommended guidelines for protecting doctors from frivolous or unjust prosecution.

27.03.2022	A patient namely Asha Bairwa was admitted to the hospital of Petitioner No. 1 at 11.30PM for the purpose of delivering a child.
28.03.2022	Asha Bairwa died due to Post-partum Hemorrhage (PPH) despite diligent attempts at saving her by Dr. Archana Sharma; the wife of Petitioner No. 1. The same day, an FIR u/s 302 was filed against the Petitioner No. 1 and his wife after protests by the crowd outside Petitioner No. 1's hospital.
29.03.2022	The wife of the Petitioner No. 1 committed suicide, being under the pressure of the defamatory publications, threats, and frivolous prosecutions.
20.04.2022	Hence, this writ petition in public interest under Article 32 of the Constitution of India.

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION
WRIT PETITION (CIVIL) NO. _____ OF 2022
[UNDER ARTICLE 32 OF THE CONSTITUTION OF INDIA]
PUBLIC INTEREST LITIGATION

IN THE MATTER OF:

- 1. Dr.Suneet Kumar Upadhyaya**
Prankur Kothun Road, Anand Hospital,
Lalsot, Dausa, Rajasthan- 303503
- 2. Dr. Kaushal Kant Mishra**
Flat No.2, 2nd Floor, SRK Apartments,
Sultanpur, Mehrauli, New Delhi – 110030
- 3. Dr Vishwa Priya Sharma**
D 159 A, GF, Freedom fighter enclave,
IGNOU Road, New Delhi-110068

...Petitioners

VERSUS

- 1. Union of India**
Through Secretary,
Ministry of Health & Family Welfare,
Government of India, Room No. 348; ‘A’ Wing,
Nirman Bhavan, New Delhi-110011
- 2. State of Rajasthan**
Through its Chief Secretary,
Government Secretariat,
Jaipur–302005
- 3. State of Uttar Pradesh**
Through its Chief Secretary, 1st Floor,
Room No. 110, Lalbahadur Sastri Bhawan,

Uttar Pradesh Secretariat,
Lucknow-2260012

4. **State of Haryana**
Through its Chief Secretary,
Room No. 4, 4th Floor, Haryana Civil Secretariat,
Sector-1 Chandigarh-160019
5. **State of Gujarat**
Through its Chief Secretary,
Block No. 1, 3rd Floor, New Sachivalaya,
Gandhi Nagar- 382010
6. **State of Jharkhand**
Through its Chief Secretary,
Project Bhawan, I Floor, Dhurwa,
Ranchi-834004
7. **State of National Capital Territory of Delhi**
Through its Chief Secretary,
Players Building, I. P. Estate, Delhi
8. **State of Jammu and Kashmir**
Through its Chief Secretary,
Room No. 2/7, 2nd Floor,
Main Building, Civil Secretariat,
Jammu-180001 and Room No. 307,
3rd Floor, Civil Secretariat, Srinagar-190001
9. **State of Karnataka**
Through its Chief Secretary,
Secretariat, M. S. Building, Vidana Soudha,
Bangalore- 560001
10. **State of Madhya Pradesh**
Through its Chief Secretary, Mantralaya,
Bhopal-4620033

11. **State of Maharashtra**
Through its Chief Secretary,
Room No. 518, 5th Floor,
Madame Cama Road, Mumbai– 400032
12. **State of Punjab**
Through its Chief Secretary,
Room No 28, 6th Floor,
Punjab Civil Secretariat, Pin160019
13. **State of Assam**
Through its Chief Secretary,
Assam Secretariat, C Block, 3rd Floor,
Dispur, Guwahati– 781006
14. **State of West Bengal**
Through its Chief Secretary,
Nabanna, 13th Floor, 325, Sarat Chatterjee Road,
Mandirtala Shibpur, Howrah-711102
15. **State of Nagaland**
Through its Chief Secretary,
Civil Secretariat, Kohima-797004, Nagaland
16. **State of Himachal Pradesh**
Through its Chief Secretary,
H. P. Secretariat, Shimali–171002
17. **State of Manipur**
Through its Chief Secretary,
Manipur Secretariat,
South Blockmphal-795001
18. **State of Andhra Pradesh**
Through its Chief Secretary,
L Block, 7th Floor, A. P. Secretariat,
Hyderabad–500022

19. **State of Kerela**
Through its Chief Secretary,
Govt. Secretariat, Thiruvananthapuram-6950014
20. **State of Tamil Nadu**
Through its Chief Secretary,
Secretariat, Chennai-600009
21. **State of Odisha**
Through its Chief Secretary,
Odisha Secretariat, Bhubaneswar-751001
22. **State of Bihar**
Through its Chief Secretary,
Main Secretariat, Patna-800015
23. **State of Arunachal Pradesh**
Through its Chief Secretary,
Civil Secretariat, Itanagar-791111
24. **State of Sikkim**
Through its Chief Secretary,
New Secretariat, Gangtok-737101
25. **State of Chattisgarh**
Through its Chief Secretary,
Mahanadi Bhawan, Mantralaya,
Naya Raipur-492002
26. **State of Goa**
Through its Chief Secretary, Secretariat,
Porvrom, Bardez-403521
27. **State of Himachal Pradesh**
Through its Chief Secretary, H.P.
Secretariat, Shimla-171002

28. **State of Meghalaya**
Through its Chief Secretary, Room No. 314,
Additional Secretariat Building,
Shillong-793001
29. **State of Mizoram**
Through its Chief Secretary,
New Secretariat Complex, Aizwal-796001
30. **State of Telangana**
Through its Chief Secretary, Block C, 3rd Floor,
Telangana, Secretariat, Khairatabad,
Hyderabad-500022
31. **State of Tripura**
Through its Chief Secretary,
New Secretariat Complex, Agartala,
West Tripura-799010
32. **State of Uttarakhand**
Through its Chief Secretary, 4 Subhash Road,
Uttarakhand Secretariat, Dehradun-248001
33. **Indian Medical Association**
Indian Medical Association,
Indraprashta Marg, IP Estate,
New Delhi, Delhi 110002
34. **Union Territory of Andaman and Nicobar**
Through its Secretary, Legal Affairs
Secretariat, District: Port Blair
35. **Union Territory of Chandigarh**
Through its Secretary, Legal Affairs
Territory Secretariat, Sector-9, Chandigarh-160009

36. **Union Territory of Dadra and Nagar Haveli**
Through its Secretary, Legal Affairs
Secretariat, District: Silvassa,
Andaman & Nicobar Island-744101
37. **Union Territory of Daman and Diu**
Through its Secretary, Legal Affairs
Secretariat, Fort Area, District: Moti Daman,
Daman, Daman & Diu- 396220
38. **Union Territory of Lakshadweep**
Through its Secretary, Legal Affairs
Secretariat, District: Kavaratti, Lakshadweep-682555
39. **The Union Territory of Puducherry**
Through its Secretary, Legal Affairs
Secretariat, Puducherry, Puducherry-605001

...Respondents

To
The Chief Justice of India and
His Companion Justices of the
Hon'ble Supreme Court of India

The Humble Petition of
the Petitioner abovenamed

MOST RESPECTFULLY SHOWETH:

1. The Petitioner is filing this Writ Petition in public interest under Article 32 of the Constitution of India to highlight the plight of registered medical practitioners and healthcare service providers, who are facing hostile action at the hands of the public and seeking issuance of guidelines that police officers should be sensitized against indiscriminate registration of criminal complaints against all healthcare service providers. Further, the Petitioner is also praying for issuance of appropriate directions pertaining to the cases of violence against healthcare service providers including directions to the Respondents for providing safety to healthcare service providers at the workplace along with directions to compensate healthcare service providers and their families in the event of violence and frivolous prosecutions.
2. The Petitioner No. 1 is a senior psychiatrist, de-addiction specialist and sexologist who runs a private hospital namely “Anand Hospital” situated at Kothun Road, Lalsot, Rajasthan-303503. The Petitioner belongs to a respected family and has himself earned the recognition and respect of the public through his accomplishments in his professional life.
3. Petitioner No.2 is a senior orthopedic surgeon, formerly at AIIMS, and presently at the super-specialty Primus Hospital, Chanakyapuri presently working as Senior Consultant, Orthopedics and Joint Replacement, Primus Hospital, Chanakyapuri,

New Delhi. Petitioner No.2 is also the President of Youth for Equality; an organization of students, teachers and professionals formed to uphold the Constitution and protect the nation from populist measures that harm its social fabric.

4. I have passed my MBBS from Delhi University in March 1976. After my residency in Safdarjung hospital, Delhi I joined Punjab Civil Medical Services (PCMS) in January 1979. I was sponsored by Punjab Govt for my MD, which I passed from Punjabi University, Patiala in December, 1984. Left PCMS in May, 1986 and joined MCD as a medical officer. I left this job in December, 1988 and started working as consultant Anaesthetist in various nursing homes in South Delhi, which is continuing till date
5. Petitioner No.3 is a senior Anaesthetist providing his services for over 30 years in Delhi. Petitioner No.3 has been a resident doctor at Safdarjung Hospital, Delhi and later joined Punjab Civil Medical Services (PCMS) in January 1979. Petitioner No.3 was sponsored by the government of Punjab for Doctor of Medicine (MD), which he cleared in December, 1984. Later, in 1986 Petitioner No. 3 MCD Hospital and worked there till 1988.
6. The details of the Petitioners are as under:

Name	Dr. Suneet Kumar Upadhyay	Dr. Kaushal Kant Mishra	Dr Vishwa Priya Sharma
Postal Address	Prankur Kothun Road, Anand Hospital, Lalsot, Dausa, 27-Rajasthan, 91-India, 303503	Flat No.2, 2 nd Floor, SRK Apartments, Sultanpur, Mehrauli, New Delhi – 110030	D 159 A, GF, Freedom fighter enclave, IGNOU Road, New Delhi-110068
Mobile No	+91 7297090998	+91 9871551323	+91 9311046106
Email Id:	anandhospitallalsot@gmail.com	gkkmihra@gmail.com	docvishu54@gmail.com
Occupation	Doctor	Doctor	Doctor
Annual Income	46,84,370/-	25,00,000/-	2,42,000/-
PAN No:	AAYPU1067F	AIMPM4994M	ABAPS5671C
Aadhar No.	5305-0530-5605	7907-1963-6846	3380-3047-6536

7. The Petitioners have not filed any other petition either in this Hon'ble Court or in any High Court seeking similar reliefs. The Petitioners are involved in no litigation which has or could have any nexus whatsoever with this petition. The Petitioners have no other alternate efficacious remedy for the relief prayed for in this petition.

8. The Petitioners have no personal interests, individual gain, private motive or oblique reasons behind filing this PIL. The Petitioners have filed this petition with *bona fide* intentions solely towards the end of public and national interest. The Petitioners have moved this Hon'ble Court for protection of the rights of medical practitioners as a class, after suffering a personal tragedy as highlighted below.
9. The Respondents are the Union of India through the Ministry of Health and Family Welfare along with all state governments through their respective Chief Secretaries and Indian Medical Association all of whom are likely to be affected by the outcome of these proceedings. The Respondents are "States" under Article 12 of the Constitution of India.
10. The facts leading to the filing of this Writ Petition are as under:

The case of the suicide of Petitioner's wife

- a) The Petitioner No. 1 himself, being a doctor (psychiatrist) used to run a private hospital in the name and style of Anand Hospital with his wife Dr. Archana Sharma who was a gynecologist. On 27.03.2022, a patient namely Asha Bairwa was admitted to the hospital of Petitioner No. 1 at 11.30PM for the purpose of delivering a child.
- b) It is pertinent to mention that the patient, Asha Bairwa's one prior delivery took place at the Petitioner No. 1's hospital. It is pertinent to note that this time;

- the patient was pregnant for the third time, in her second pregnancy she gave birth to twin healthy girl after a successful C-section operation at the Petitioner No. 1's hospital. It is due to this reason that the Patient's family trusted the Petitioner and his wife therefore, for the patient's third child, they again trusted the Petitioner No. 1's Hospital, despite being referred to the Government Hospital. However, during this pregnancy the Patient was facing certain pre-existing complications which were handled by the Petitioner No. 1 and his wife with utmost care.
- c) When the patient arrived at the Petitioner No. 1's hospital, 1 unit of blood was supplied to her due to low hemoglobin count before childbirth. The Petitioner No. 1's wife Dr. Archana Sharma operated the patient the next morning on 28.03.2022 at around 09.00 AM. As a result, a healthy male child was born to the patient.
- d) At around 11.00 AM, after the C-Section delivery of her child, the patient developed Post-partum Hemorrhage. In a two-hour long attempt to save the patient, the Petitioner No. 1's wife Dr. Archana Sharma tried everything in her capacity, this included attempts to stop uterine bleeding and supply of two more units of blood. However, despite all the efforts of the doctor, the patient died at around 01.30 PM.

- e) Upon request of the patient's family, the Petitioner No. 1 and his wife arranged an ambulance for carrying the deceased; also, the Petitioner No. 1 and his wife returned an amount of Rs. 12,000/- deposited by the family of the patient. At around 04.00 PM, the family of the deceased patient along with some local political leaders collected outside the Petitioner No. 1's hospital and started protesting, they also placed the dead body outside the hospital. The political leaders also threatened the Petitioner No. 1 and his father. At this protest, the Dy. SP and SHO of the area were also available. It is pertinent to note, that the Dy. SP and SHO, in fact pressurized the Petitioner No. 1 and his wife instead of disbursing the crowd.
- f) Later, on the same day i.e. 28.03.2022, an FIR No. 0155 under section 302 of IPC was registered against the Petitioner No. 1 and his wife at the Lalsot Police Station by the patient's husband stating that the doctors were negligent in discharge of their duties towards the patient. Further on 29.03.2022, several defamatory articles were published in the local newspapers against the Petitioner No. 1 and his wife. True translated copy of the FIR No. 0155 u/s 302 of IPC dated 28.03.2022 registered at Lalsot Police Station, Dausa is annexed as **Annexure P-1** (from pages **36 -43**__).
- g) Thereafter on 28.03.2022, a group of senior doctors met the Superintendent of Police (SP) of the city to discuss that the doctors cannot be charged u/s 302 of IPC as they lack the essential ingredient of *mensrea* to be charged with murder

of a patient. Despite the humble requests from various requests from senior doctors, the SP refused to take down the charge u/s 302 IPC.

- h) Under the pressure of the defamatory publications and threats, the wife of the Petitioner No. 1 became upset and depressed which led her to commit suicide on 29.03.2022. The Petitioner No. 1's wife left behind a suicide note wherein she stated that Post-partum Hemorrhage (PPH) is a known condition for which a doctor should not be harassed. True translated copy of the suicide note dated 29.03.2022 written by Petitioner No. 1's deceased wife with Original is annexed as **Annexure P-2** (from pages __44-45__).
- i) The news of the suicide of Petitioner No. 1's wife Dr. Archana Sharma shocked the entire nation. This led to protests by doctors as well as ordinary citizens across the country. As a consequence, the SP, being under fear amended the charge from section 302 to section 304A of IPC against the Petitioner No. 1. However, the fact remains that an FIR has been registered without any justification.
- j) The Petitioners firmly believe that the Constitution of India guarantees life and liberty, justice and equality for all citizens. Therefore, they have moved this Writ Petition under Article 32 of the Constitution of India, which seeks to invoke the most salient fundamental right i.e., the right to life guaranteed under Article 21 to all healthcare service providers. The petition pertains to the

ongoing incidents of violence and criminal implications against doctors and other healthcare service providers that have assumed dangerous proportions throughout the country. Over the past few years, India has been witnessing a sharp rise in such unfortunate cases against healthcare service providers which is not only resulting in loss of reputation to the affected healthcare service providers, but also resulting in erosion of the mutual trust between the doctors and the patients. The Petitioner No. 1 personally has suffered as highlighted above.

Existing guidelines of this Hon'ble Court

- k) It is submitted that this Hon'ble Court has in various pronouncements opined that a medical professional cannot be proceeded against with criminal charges seeking punishment in every case of mishap or death. This Hon'ble Court has also observed that the investigation officer should seek a medical / expert opinion before proceeding with charges against a healthcare service provider.
- l) In 2004, this Hon'ble Court in *Dr. Suresh Gupta v. Govt. of NCT of Delhi*, 2004 6 SCC 422 has clarified that criminal charges can only be filed against a medical man only when the medical man exhibits a gross lack of competence or inaction to his patient's safety and which is found to have arisen from gross ignorance or gross negligence. Only in cases of gross ignorance or gross negligence can a criminal liability under Section 304A IPC be imposed. The

said Criminal liability cannot be attached to a healthcare service provider in case of a mere error of judgment or an accident.

- m) This Hon'ble Court also emphasized on the importance of prosecution of doctors on the basis of adequate medical / expert opinion and noted that:

“23. 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.”

A true copy of the judgment title as *Suresh Gupta v. Govt. of NCT of Delhi [2004 6 SCC 422]* of this Hon'ble Court dated 04.08.2004 is annexed as **Annexure P-3** (from pages **46-55**).

- n) In the 2005 decision of *Jacob Mathew v. State of Punjab [2005 6 SCC 1]*, this Hon'ble Court noted that medical science is too complex to be understood. To hold a healthcare service provider criminally liable for negligence, an in-depth

understanding of nature of the act is required which does not necessarily involve the element of culpability.

- o) It is pertinent to note that this Hon'ble Court in the case of *Jacob Mathew (Supra)* also noted that the treatments of patients by healthcare service providers specially doctors are done with consent and in good faith, therefore, fall under the Section 88 of IPC i.e., General Exceptions.

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 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.

Illustration: "A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under the painful complaint, but not intending to cause Z's death, and intending, in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence."

- p) In the decision of *Jacob Mathew (Supra)* this Hon'ble court also noted the importance of a doctor performing freely from fear of legal actions and said:

“28. 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.”

- q) In *Jacob Mathew (Supra)* this Hon’ble court laid down specific guidelines for prosecution of medical professionals. This Hon’ble Court taking an opinion similar to that in *Dr. Suresh Gupta (Supra)* observed that:

“52...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 and unbiased opinion applying Bolam's test to the facts collected in the investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been levelled against him)...”

(Emphasis Supplied)

A true copy of the judgment title as *Jacob Mathew v. State of Punjab* [2005 6 SCC 1] of this Hon'ble Court dated 05.08.2005 is annexed as **Annexure P-4** (from pages **56-91**).

- r) In a 2010 decision of *Kusum Sharma v. Batra Hospital*, [2010 3 SCC 480], this Hon'ble Court reiterated the guidelines laid down in *Jacob Mathew* (*Supra*) and also laid down certain principles to be followed while dealing with the charge of medical negligence against medical professionals.

“89... VI. *The medical professional 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. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.*

VIII. *It would not be conducive to the efficiency of the medical profession if no Doctor could administer medicine without a halter round his neck.*

IX. *It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessary harassed or humiliated so that they can perform their professional duties without fear and apprehension.*

X. The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurizing the medical professionals/hospitals particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

XI. The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals.”

(Emphasis Supplied)

A true copy of the judgment title as *Kusum Sharma v. Batra Hospital*, [2010 3 SCC 480] of this Hon’ble Court date 10.02.2010 is annexed as **Annexure P-5** (from pages **92-119**).

- s) Hon’ble High Court of Allahabad in *Dr. Mohd. AzamHasin v. State of UP*, 2020 1 All LJ 662 noted the recent increase in cases of implication of doctors in legal proceedings after the demise of a patient.

“27...A doctor in the Indian society is the most revered person, who is given status of God in case the patient survives. But we all know that in cases like the present one, risk is always involved and when the patient/family members give consent for being operated, they give

consent for such kind of operation to be conducted and to bear the consequences. It is also noticed in the recent past that the cases to implicate the doctors after demise of the patient have increased, some on account of extortion of illegal money from the doctors and some due to other reasons, only to harass the doctors, out of frustration and because of these factors, the guidelines have been laid down by Hon'ble Apex Court in the case of Jacob Mathew v. State of Punjab and Another and also recently, in the case of Kusum Sharma (supra), which have been narrated above.."

(Emphasis Supplied)

- t) It is important to note that it has been almost over two decades since this Hon'ble Court first issued guidelines in the case of *Jacob Mathew (Supra)*. However, to an utter disappointment of all healthcare service providers, there has been no compliance of the orders of the apex court and the cases of violence as well as frivolous prosecutions against healthcare service providers have continued to rise exponentially. Even in the Petitioner's case, the FIR has been lodged indiscriminately without understanding the incident which took place and without understanding that there was no negligence involved, much less of a nature to attract criminal prosecution.

Cases of violence against healthcare service providers

- u) It is humbly submitted that during the unprecedented times of covid-19 pandemic, all healthcare service providers have come forward in saving millions of lives. However, on the other hand, as noted above, violence and criminal implications against the doctors and other healthcare service providers have continued to rise exponentially despite categorical guidelines laid down in aforementioned cases. Some other examples other than what the Petitioner has personally suffered are highlighted below.

- v) In April 2021, a 72-year-old lady was admitted to the Swaroop Rani Hospital in Prayagraj as she suffered from serious medical problems including high fever. A few days later on 23.04.2021, the patient passed away despite proper care and medical attention. Following the patient's death, the family of the patient refused to remove the body from the hospital bed, started abusing and threatening the doctors. Moments later, the family of the patient assaulted the resident doctors at the hospital. The police officers also did not pay attention to the issue despite repeated requests. True copy of the news report dated 24.04.2021 published by The Times of India is annexed as **Annexure P-6** (from pages_120-122_).

- w) On 24.05.2021, reports of the relative of a COVID-19 patient assaulting a doctor in Ballari had also surfaced. In a video of the incident, a man stormed into the COVID-19 ward of the VIMS Hospital and was seen assaulting a woman doctor after arguing with her. The assaulter's father was being treated

- at the hospital for COVID-19 who passed away due to complications caused by the infection. True copy of the news report dated 24.05.2021 published by The New Indian Express is annexed as **Annexure P-7** (from pages_123-124_).
- x) On 29.05.2021, Karnataka based Dr. Deepak was assaulted by four men who were family members of a 6-year-old child who died of Dengue complications despite proper medical attention on 7.05.2021. Dr. Deepak sustained injuries on his hands, legs and head. All 4 assaulters were charged with attempt to murder of Dr. Deepak. True copy of the news report dated 03.06.2020 published by NDTV is annexed as **Annexure P-8** (from pages_125-126_).
- y) One of the most heinous attacks occurred on 29.07.2020 in Latur, Maharashtra where one Dr Dinesh Varma, head of Alfa Specialty Hospital was grievously stabbed in several places by the relative of a COVID 19 patient who succumbed to the disease. The attackers of Dr. Dinesh Verma were charged under section 307 IPC. True copy of the news report dated 30.07.2020 published by Mumbai Mirror is annexed as **Annexure P-9** (from pages_127-128_).
- z) On 01.06.2021, a video went viral wherein Dr. Seuj Kumar Senapati was brutally assaulted at the Udai Covid Care Centre in Hojai District of Assam. The assault was done by more than 30 people, most of them the family

members of a covid-19 patient who was already dead when brought to the hospital. When the doctor informed the family that the patient is already dead, they started vandalizing the hospital and attacked the doctor. The degree of the assault was so severe that the doctor had to undergo a surgery. True copy of the news report dated 01.06.2021 published by The Times of India is annexed as **Annexure P-10** (from pages_129-130_).

- aa) The abovementioned incidents are a mere scratch on the surface. An ongoing study by Indian Medical Association (IMA) published in the Indian Journal of Medical Research reports that 75 per cent of doctors in India have faced violence at some point of time in their life, and most of the time, it is verbal abuse. It is pertinent to mention that doctors and other healthcare service providers will not be able to discharge their duties to the optimum in such circumstances of fear of violence and legal implications. True copy of the study by Indian Medical Association (IMA) published in the Indian Journal of Medical Research in August 2018 is annexed herein as **Annexure P-11**. (from pages_131-141_).

Proposed and existing legal framework for protection of healthcare service providers

- bb) On 02.09.2019, the Ministry of Health & Family Welfare notified the draft of 'The Healthcare Service Personnel and Clinical Establishments (Prohibition of

violence and damage to property) Bill, 2019’ for objections and suggestions from public. The draft bill provides that whoever commits or abets the commission of violence or damage to property against a healthcare service personnel shall be punished with imprisonment for a term which shall not be less than six months, but which may extend to five years, and with fine, which shall not be less than fifty thousand rupees, but which may extend to five Lakh rupees. The draft bill also provides whoever while committing such violence causes grievous hurt as defined in section 320 IPC, shall be punished with imprisonment for a term which shall not be less than three years, but which may extend to ten years and with fine, which shall not be less than two Lakh rupees, but which may extend to ten Lakh rupees. However, no legislation has been enacted as yet.

- cc) In April 2020, an amendment called the Epidemic Diseases (Amendment) Act, 2020 was enacted. The Amendment Act defined ‘acts of violence’ against healthcare service personnel.

(a) “act of violence” includes any of the following acts committed by any person against a healthcare service personnel serving during an epidemic, which causes or may cause—

(i) harassment impacting the living or working conditions of such healthcare service personnel and preventing him from discharging his duties;

(ii) harm, injury, hurt, intimidation or danger to the life of such healthcare service personnel, either within the premises of a clinical establishment or otherwise;

(iii) obstruction or hindrance to such healthcare service personnel in the discharge of his duties, either within the premises of a clinical establishment or otherwise; or

(iv) loss or damage to any property or documents in the custody of, or in relation to, such healthcare service personnel.

Under Section 6 of the Amendment Act, it is provided that whoever commits or abets the commission of an act of violence against a healthcare service personnel shall be punished with imprisonment for a term which shall not be less than three months, but which may extend to five years, and with fine, which shall not be less than fifty thousand rupees, but which may extend to two Lakh rupees.

The Amendment Act also provides whoever while committing such act of violence causes grievous hurt as defined in section 320 IPC, shall be punished with imprisonment for a term which shall not be less than six months, but

which may extend to seven years and with fine, which shall not be less than one Lakh rupees, but which may extend to five Lakh rupees.

- dd) On 01.06.2021, the Indian Medical Association wrote to the Home Minister of India drawing his attention to cases of violence and frivolous prosecution against healthcare service providers. In its letter, the Indian Medical Association urged the Home Minister to bring in a strong and comprehensive law aimed at protecting the violence and frivolous prosecution of healthcare service providers.
- ee) On 29.09.2021, the National Medical Commission wrote to the Ministry of Health & Family Welfare wherein it recommended guidelines for protecting doctors from frivolous or unjust prosecution, on the lines of the guidelines laid down in *Jacob Mathew (Supra)*. In its recommendations, the National Medical Commission proposed that the investigating agency shall make a reference to the District Medical Board, which upon receipt of such reference shall within two weeks provide its recommendations. In case the investigating agency is dissatisfied by the recommendations of the District Medical Board it may approach the State Medical Board. The National Medical Commission also mentions that the arrest of a doctor must only take place when necessary.
- ff) It is submitted that despite the clear guidelines issued earlier by this Hon'ble Court, the life savers of this country continue to work under circumstances

guided by fear of being wrongfully dragged to court or the fear of violence for performing their duties.

gg)The Petitioner further submits that it becomes the need of the hour that certain directions be issued by this Hon'ble Court to the Respondents to ensure that guidelines already laid down in *Jacob Mathew* and *Dr. Suresh Mehta* must be followed and that such rising instances violence and criminal implication against medical professionals be curbed.

11. The present writ petition is hence preferred on the following grounds which are taken without prejudice to each other –

GROUND

- A. Because the medical fraternity is duty bound to serve the people, and this duty cannot be discharged if there is a pervasive fear of attacks and criminal prosecution against doctors.
- B. Because there are rising instances of violence against doctors at the hands of the public, as also instances of doctors being made to face criminal prosecution, without either the public or the police having any understanding of the actual issues involved regarding the treatment of patients.
- C. Because despite existing guidelines and observations issued by this Hon'ble Court in *Jacob Mathew*, *Dr. Suresh Mehta* and other cases, there is no effort

made by the respective State Governments to sensitize the police force to provide protection to doctors and refrain from filing initiating baseless prosecutions against the medical professionals.

- D. Because the human body is too complex to be easily understood by a person who lacks the required knowledge. Coupled with the complexities of medical science, the scope for misimpressions, misgivings and misplaced allegations against the operator i.e. the doctor, cannot be ruled out. Therefore, the issue of prosecution of a healthcare service provider arising out of medical problem of a patient is beyond the understanding of a police officer who has almost no knowledge of medical science.
- E. Because the criminal cases pertaining to healthcare service providers are special as they require expert opinion. A police officer cannot charge healthcare service providers merely on the basis of public sentiments in a knee jerk reaction to such sentiments against healthcare service providers.
- F. Because this Hon'ble court has noted in *Dr. Suresh Gupta (Supra)* that such complex cases involving knowledge of medical science and human body need expert medical opinion:

“23. 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.”

Similarly in *Jacob Mathew (Supra)*, this Hon’ble Court noted:

“52...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 and unbiased opinion applying Bolam's test to the facts collected in the investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been levelled against him)...”

(Emphasis Supplied)

There is an urgent need of strict compliance with the guideline of the apex court by all the responding governments. In cases of prosecution of doctors and other healthcare service providers, an expert medical opinion must be sought.

- G. Because all the government and even private hospitals lack proper measures of safety and security of healthcare service providers against cases of

violence arising out of any mishap or deaths of patients. The same is evident by plethora of cases of violence against healthcare service providers and destruction of property at hospitals.

- H. Because the treatment of patient by healthcare service providers is done with the consent of the patient and family members and in good faith. Since, no act of a healthcare service provider is intended to cause harm to the patient, it therefore falls under the Section 88 of IPC i.e., General Exceptions. In such situation attacks against doctors and prosecution of doctors is uncalled for.
- I. Because over the decades, the healthcare service providers have been constant victims of frivolous prosecutions and harassments. In the recent past, the cases to implicate the healthcare service providers after demise of the patient have increased, some on account of extortion of illegal money from the doctors and some due to other reasons, only to harass the doctors and other healthcare service providers, out of frustration. Such frivolous proceedings have to be guarded against.
- J. Because these constant instances of violence and criminal implications not only result in loss of life / health of healthcare service providers but also results in a huge loss of reputation of such healthcare service providers. Therefore, it becomes pertinent that certain guidelines be put in place for providing compensation to healthcare service providers and their families in the event of violence, frivolous prosecutions and resulting loss of health and reputation.

- K. Because these continuing instances of violence and frivolous prosecution against healthcare service providers have given rise to erosion of faith from the medical system of the country. There has also been a lack of mutual trust between the doctors and the patients.
- L. Because the right to health is a fundamental right guaranteed to every citizen of India under Article 21 of the Constitution of India and the government is under obligation to safeguard the right to health *vis a vis* Right to Life under article 21. As observed in *Paschim Banga Khet Mazdoor Samity & Ors. V. State of West Bengal & Anr., 1996 4 SCC 37*:

“9. The Constitution envisages the establishment of a welfare state at the federal level as well as at the state level. In a welfare state the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. The Government discharges this obligation by running hospitals and health centers which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21...”

(Emphasis Supplied)

The said obligation of the state cannot be duly discharged if the medical officers responsible for the discharge of this obligation are under the constant fear of violence and harassment. As a consequence, the right to health of all

citizens is being violated on accounts of violence and frivolous prosecution against healthcare service providers and leads to failure of the government in discharging its constitutional obligations.

M. Because the Petitioner No. 2 and 3 are both medical practitioners with decades of standing in the medical profession and are very well known in their respective branches of medicine. Over these years, both Petitioner No. 2 and 3 have been witnessing such instances of violence and frivolous prosecution against their fellow medical practitioners and are deeply affected by the plights of entire medical fraternity.

N. Because in such circumstances intervention of this Hon'ble Court is required to protect the medical fraternity.

12. That no civil, criminal or revenue litigation involving the Petitioner herein, which has legal nexus with the issues involved in the instant PIL, are pending before any court in the country.

PRAYERS

In light of the above, the Petitioner most humbly prays that this Hon'ble Court may be pleased to:


I. ISSUE a writ of Mandamus directing all the Respondents to strictly comply with the guidelines and principles as laid down by this Hon'ble Court in the cases of *Jacob Mathew v. State of Punjab 2005*

6 SCC 1 and Dr. Suresh Gupta v. Govt. of NCT of Delhi, 2004 6 SCC 422;

- II. ISSUE appropriate directions to all the Respondents to sensitize police officers against prosecuting healthcare service providers, including guidelines for penal actions against police officers for wrongfully charging healthcare service providers without medical / expert opinion;
- III. ISSUE appropriate directions to all the Respondents to issue comprehensive guidelines for providing safety to healthcare service providers at their workplace;
- IV. FRAME AND ISSUE guidelines for providing compensation to healthcare service providers and their families in the event of violence and frivolous prosecutions;
- V. PASS any such other orders as this Hon'ble Court may deem fit in the facts and circumstances of this case.

And for this act of kindness the Petitioner as in duty bound shall ever pray.

Place: New Delhi
Filed on: 20.04.2022

Filed by:

POOJA DHAR
Advocate for the Petitioners

CIVIL ORIGINAL JURISDICTION

WRIT PETITION (CIVIL) NO. _____ OF 2022

[UNDER ARTICLE 32 OF THE CONSTITUTION OF INDIA]

PUBLIC INTEREST LITIGATION

IN THE MATTER OF:

Dr. Suneet Kumar Upadhyaya

.....Petitioner

Versus

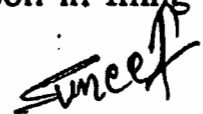
Union of India & Ors.

.....Respondent

AFFIDAVIT

I, Dr Suneet Kumar Upadhyaya , S/o Sh. Ashok Kumar Upadhyaya, aged about 45 years, resident of Anand Hospital, Kothun road, lalsot, Dausa, Rajasthan. 303503, do hereby state and solemnly affirm as under:

1. That I am the Petitioner in the above matter and I am conversant with the fact and circumstances of the case and hence competent to swear to this affidavit.
2. I say that I have read and understood the contents of the accompanying Writ Petition from para 1 to 12 at page no. 1 to 33 and the Synopsis and list of dates, pages B to I and Applications and I say that the facts stated therein are true to the best of my knowledge and belief
3. I say that the Annexures along with the Writ Petition are true copies of their respective originals.
4. That there is no person gain, private motive or oblique reason in filing the PIL.

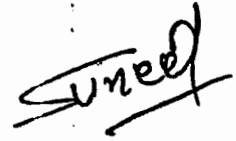


DEPONENT

VERIFICATION

I, the deponent above named do hereby verify and state that the contents of the above affidavit are true and correct to the best of my knowledge and belief and that nothing material has been concealed herefrom.

Verified this at on this ^{17th} day of April 2022 .



DEPONENT

ANNEXURE: P-1

N.C.R.B.

I.I.F-I

FIRST INFORMATION REPORT

(Under Section 154 Cr.P.C.)

1. District : Dausa P.S.: Lalsot Year: 2022
FIR No.: 0155 Date and Time of FIR: 28/03/2022
18:50 hours

2.

Sl. No.	Acts	Sections
1	I.P.C. 1860	302

3. (a) Occurrence of offence:

1. Day: Monday Date From: 28/03/2022 Date To: 28/03/2022

Time period:?? Time From:00:00 Time To: 00:00

(b) Information received at P.S.: Date:28/03/2022 Time:18:50

(c) General Diary Reference: Entry No.: 048 Time:28/03/2022

4. Type of information: Written

5. Place of occurrence:

1. (a) Direction and distance from P.S.: West, 7 km.

Beat No.:

(b) Address: Anand Hospital Lalsot

(c) In case, outside the limit of this Police Station, then:

Name of P.S.:

District (State) :

6. Complainant/Informant:

(a) Name : Laluram Bairwa

(b) Father's/ Husband's name:

(c) Date/Year of Birth: 1994 (d) Nationality: Indian

(e) UID No.:

(f) Passport No.: Place of Issue:

Date of Issue:

(g) Id details (Rational Card, Voter ID Card, Passport, UID

No. Driving License, PAN)

Sl. No.	Id Type	Id Number

(h) Occupation:

(i) Address:

Sl. No.	Address Type	Address
1.	Present Address	Khoja Ki Dhani Bherubas, Lalsot, Dausa, Rajasthan, India
2.	Permanent Address	Khoja Ki Dhani Bherubas, Lalsot, Dausa, Rajasthan, India

(j) Phone number: Mobile No.: 91-7891163835

7. Details of known/suspected/unknown accused with full particulars:

Accused More Than:

Sl. No.	Name	Alias	Relative's Name	Present Address
1.	Sunit Upadhyay Total 2Hemant Aggarwal of Wage to Capital Company			1. Anand Hospital Lalsot, Dausa, Rajasthan, India

8. Reasons for delay in reporting by the complainant/informant:

9. Particulars of properties of interest:

Sl. No.	Property Category	Property Type	Description	Value (in Rs.)
				0

10. Total value of property(In Rs./-) :

Inquest Report / U.D. Case No. if any:

S. No.	UIDB

11. Inquest Report / U.D. case No., if any:

S. No.	UIDB Number

12. First Information contents:

To, The Station House Officer, Police Station Lalsot, Dausa, Rajasthan. Subject: With regard to register Report. It is submitted in the above subject that I, Laluram son of Kajodmal Bairwa am the resident of Khojya Ki Dhani, Khemavas, Bhairuvas. My wife Asha Devi was pregnant, she was got examined in Maternal Child Welfare Center and the doctor there referred her to Dausa Government Hospital. Applicant Laluram Bairwa consulted Dr. Sunit Upadhyay and Madam Dr. Archana, owner of Anand Hospital Lalsot. At this, Dr. Sunit and Dr. Archana asked the applicant to bring her

there and they will get the delivery done. After talking to them the applicant took an ambulance on rent and reached Anand Hospital. The mother of the child died due to the negligence of the doctor. After committing negligence, they came back leaving the deceased at her house from their personal ambulance without handing over the deceased to the applicant and they had also come back leaving the newly born baby with the deceased. Applicant Laluram was unconscious at that time. The newly baby was to be kept in the care of hospital till 48 hours as per rules. Therefore, it is requested from the Station House Officer, Police Station, that after taking cognizance on the report, action be taken against Dr. Sunit and Madam Archana Sharma and cancel the licence of Anand Hospital. Applicant Laluram Bairwa son of Shri Kajodmal, caste Bairwa, aged 28 years, resident of Khojya Ki Dhani, Police Station Lalsot, Mob. No.7891163835. Police action: The above report was written in Hindi. Shri Laluram Bairwa son of Shri Kajodmal Bairwa, Caste Bairwa, aged 28 years, resident of Khojya ki Dhani, Bhairuwas Chak No.2, Police Station Lalsot, district Dausa came at police station and submitted a report which was copied on CCTNS Computer word by word. On interrogation, he told that the dead body of his wife is kept at the gate of Anand Hospital. On finding commission of offence under Section 302 IPC on the basis of report and statement of applicant, a case was registered under Section 302 IPC and the investigation of the case was handed

over to me S.I. Ankesh Kumar by the Station House Officer. Copies of F.I.R./S.R. were issued as per rules. On automatic generation of FIR Number from CCTNS, the same will be recorded separately.

13. Action taken: Since the above information reveals commission of offence(s) u/s. as mentioned as Item No.2

(1) Registered the case and took up the investigation: Ankesh
Kumar Or

(2) Directed (Name of I.O.): Rank:
No.: to take up the investigation

(3) Refused investigation due to: Or

(4) Transferred to P.S.: District:
on point of jurisdiction.

F.I.R. read over to the complainant/informant, admitted to be correctly recorded and a copy given to the complainant/informant free of cost.

R.O.A.C.

14 Signature / thumb impression of the complainant /informant Signature of Officer in charge, Police Station

15 Date and time of Name: Ankesh Kumar
 dispatch to the court Rank: SI (Sub-Inspector)
 No.:

Attachment to item 7 of First Information Report:

Physical features, deformities and other details of the
 suspect/accused: (If known / seen)

S. No.	Sex	Date / Year of birth	Build	Height (cms.)	Complexion	Identification Mark(s)
1	2	3	4	5	6	7
1	Male	1977				

Deformities / Peculiarities	Teeth	Hair	Eye	Habit(s)	Dress Habit

8	9	10	11	12	13

Language / Dialect	Place of					Others
	Burn Mark	Leucoderma	Mole	Scar	Tattoo	
14	15	16	17	18	19	20

These fields will be entered only if complainant/informant gives any one or more particulars about the suspect/accused.



True Translated copy

ANNEXURE:P-2

I love my husband and my children, a lot. Please do not trouble them after my death.

I have not committed any mistakes, haven't killed anyone, PPH is a known complication, stop harassing innocent doctors for this.

I hope my death proves my innocence.

Don't harass innocent doctors.

Please.

Love You, Please don't let my children feel the absence of a mother.

~Archana Sharma.



TRUE TRANSLATED COPY

मैं मेरे पति, मेरे बच्चों से बहुत प्यार
 करती हूँ। कृपया मेरे मेरे मरने के बाद
 इन पर शासन नहीं करना।
 किसी को नहीं कोई शक्ती नहीं थी,
 किसी को नहीं मारा PPH एक known
 complication है इसके लिए बुल्डर
 को इतना प्रताड़ित करना बन्द करो
 मेरे मरना शायद मेरी बेगुनाही
 साबित कर दे।

DON'T HARASS INNOCENT
 DOCTORS.

Please.

Love U Please मेरे बच्चों को माँ
 की कमी महसूस नहीं होने देना

Deedaraj
 Sharma

422 SUPREME COURT CASES (2004) 6 SCC

4. It is submitted by the learned counsel for the appellant that the TADA Act stood repealed on 24-5-1995 and an act done after the repeal of the Act cannot be held punishable by reference to that Act. There is merit in the submission of the learned counsel for the appellant. The learned counsel for the State has in her opposition to the appeal and in her effort at supporting the impugned judgment of the Designated Court, carried us through the averments made in the charge-sheet as also to the contents of the confessional statement of the appellant. Nothing can be found out therein to hold the involvement of the appellant in any criminal activity punishable under the TADA Act and relatable to a date prior to its repeal i.e. during the period the Act was in force. The appellant cannot, therefore, be tried by the Designated Judge under the TADA Act. a

5. The appeals are allowed. The charge framed by the learned Designated Judge against the appellant under Sections 3(3) and 3(4) of the TADA Act is directed to be quashed. However, we clarify that the appellant is not absolved of the liability for being proceeded against under any law under which his act may be punishable excepting under the TADA Act. b

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(BEFORE Y.K. SABHARWAL AND D.M. DHARMADHIKARI, JJ.) c

DR. SURESH GUPTA . . . Appellant; d

Versus

GOVT. OF NCT OF DELHI AND ANOTHER . . . Respondents. e

Criminal Appeal No. 778 of 2004[†], decided on August 4, 2004

A. Penal Code, 1860 — S. 304-A — Liability of doctors under, for death due to medical negligence — Degree of negligence required to be proved — Held, where a patient dies due to negligent medical treatment of a doctor, if the degree of negligence is so gross and the act of the doctor was so reckless as to endanger the life of the patient, the doctor would be made criminally liable, in addition to any civil liability in tort — For every mishap or death during medical treatment however, the medical man cannot be proceeded against for punishment — Reason therefor set out — Tort — Medical negligence f

B. Penal Code, 1860 — S. 304-A — Degree of medical negligence necessary to attract provisions of — Death due to negligence in performance of rhinoplasty — Cause of death stated to be non-introduction of endotracheal tube of proper size to prevent aspiration of blood from wound in respiratory passage — Held, such act, even if attributed to be true, can be described as a negligent act as there was lack of due care and precaution, which may attract liability in tort but the carelessness or want of due attention and skill cannot be described to be so reckless or grossly negligent as to attract criminal liability — Tort — Medical negligence — Standard of care g

[†] Arising out of SLP (Crl.) No. 2931 of 2003. From the Judgment and Order dated 1-4-2003 of the Punjab and Haryana High Court in Crl. Revision Petition No. 100 of 2003 h

Allowing the appeal and quashing the criminal proceedings against the accused, the Supreme Court

a Held :

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 so reckless as to endanger the life of the patient, he would also be made criminally liable for offence under Section 304-A IPC. (Para 12)

b

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. 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

c

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. 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 the 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. (Paras 20 to 23, 25 and 26)

e

R. v. Adomako, (1994) 3 All ER 79 (HL), *relied on*
Suleman Rehiman Mulani v. State of Maharashtra, (1968) 2 SCR 515 : 1968 Cri LJ 1013;
Laxman Balkrishna Joshi v. Trimbak Babu Godbole, (1969) 1 SCR 206 : AIR 1969 SC 128, *cited*

f

Alan Merry and Alexander McCall Smith: *Errors, Medicine and the Law*, pp. 247-48, *relied on*

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 endotracheal tube of proper size as to prevent aspiration of blood from the wound in the respiratory passage”.

g

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. (Para 24)

h

C. Criminal Procedure Code, 1973 — S. 482 — Requirements for attraction of — On facts, complaint for offence under S. 304-A, Penal Code, quashed

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It is settled position in law that the inherent power of the High Court under Section 482 CrPC 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. 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. (Para 8)

Municipal Corpn. of Delhi v. Ram Kishan Rohtagi, (1983) 1 SCC 1 : 1983 SCC (Cri) 115 : AIR 1983 SC 67; *Drugs Inspector v. Dr. B.K. Krishnaiah*, (1981) 2 SCC 454 : 1981 SCC (Cri) 487 : AIR 1981 SC 1164, *relied on*

After examining all the medical papers accompanying the complaint, it is found that no case of recklessness or gross negligence has been made out against the doctor to compel him to face trial for offence under Section 304-A IPC and the criminal proceedings pending against the present doctor who is the accused and appellant are quashed. (Para 28)

D-M/TZ/30281/CR

Advocates who appeared in this case :

Ashok H. Desai, Senior Advocate (Alok Kr. Sengupta, Ms Sushma Sharma, Meghalee Barthakur, Mrinal Kanti Mandal, Ms Anindita Sengupta, Rajan Narain and Suraj Prakash, Advocates, with him) for the Appellant;

Harish Chander, Senior Advocate (S. Wasim A. Qadri, Vineet Malhotra, Ms Anil Katiyar and Nikilesh Ramachandran, Advocates, with him) for the Respondents.

<i>Chronological list of cases cited</i>	<i>on page(s)</i>
1. (1994) 3 All ER 79 (HL), <i>R. v. Adomako</i>	426a, 429c
2. (1983) 1 SCC 1 : 1983 SCC (Cri) 115 : AIR 1983 SC 67, <i>Municipal Corpn. of Delhi v. Ram Kishan Rohtagi</i>	426c-d
3. (1981) 2 SCC 454 : 1981 SCC (Cri) 487 : AIR 1981 SC 1164, <i>Drugs Inspector v. Dr. B.K. Krishnaiah</i>	426c-d
4. (1969) 1 SCR 206 : AIR 1969 SC 128, <i>Laxman Balkrishna Joshi v. Trimbak Babu Godbole</i>	426a
5. (1968) 2 SCR 515 : 1968 Cri LJ 1013, <i>Suleman Rehiman Mulani v. State of Maharashtra</i>	426a

The Judgment of the Court was delivered by

D.M. DHARMADHIKARI, J.— Leave to appeal is granted.

2. 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 “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 anaesthetist 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.

3. 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 the following reasons in the impugned order dated 28-11-1998 passed by him:

“Post-mortem report is very categorical and very clear and it has been clearly mentioned therein that death was due to the complication

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a arising out of the operation. That operation was conducted by both the
accused persons. It is also clear from the material on record that the
deceased was a 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.

* * *

c It is clear from the record that the 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 304-A IPC. Let
notice be served accordingly.” (emphasis supplied)

d 4. 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:

e “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 doctors concerned when they are examined during the
trial.”

g 5. 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 304-A IPC has been made out. He submits
that in the larger interest of medical profession, the criminal proceedings
h instituted against his client deserve to be quashed.

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6. Reliance is placed on the House of Lords decision in the case of *R. v. Adomako*¹, *Suleman Rehiman Mulani v. State of Maharashtra*² and *Laxman Balkrishna Joshi v. Trimbak Babu Godbole*³.

7. We have also heard learned Senior Counsel Shri Harish Chander 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.

8. It is settled position in law that the inherent power of the High Court under Section 482 of the 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 Corpn. of Delhi v. Ram Kishan Rohtagi*⁴ and *Drugs Inspector v. Dr. B.K. Krishnaiah*⁵.)

9. 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 is the cause of death to the best of my knowledge and answers to the question put by IO.”

10. 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 to head-up position.
2. Adverse drug reaction.
3. Hypoxia.

1 (1994) 3 All ER 79 (HL)

2 (1968) 2 SCR 515 : 1968 Cri LJ 1013

3 (1969) 1 SCR 206 : AIR 1969 SC 128

4 (1983) 1 SCC 1 : 1983 SCC (Cri) 115 : AIR 1983 SC 67

5 (1981) 2 SCC 454 : 1981 SCC (Cri) 487 : AIR 1981 SC 1164

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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 endotracheal tube of proper size (8.5), which was introduced before the operation and remained in position till the patient was declared dead in Sri 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 decomposing 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
Chairman

sd/-
Dr. Rizvi
Member

sd/-
P.L. Dhingra
Member”

(emphasis supplied)

11. One of the members of the doctors’ team, Prof. Jagannatham, gave a separate report which reads as under:

“After going through the 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 an enigma 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 the anaesthetist 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 respirators) and shifted the patient to Ganga Ram Hospital’s ICU.

sd/-
(Dr. Jagannatham)
15-11-1995”

12. 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

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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 so reckless as to endanger the life of the patient, he would also be made criminally liable for offence under Section 304-A IPC. a

13. Section 304-A IPC reads thus:

“304-A. *Causing death by negligence.*—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 extend to two years, or with fine, or with both.” b

14. On behalf of the doctor learned counsel referred to Section 80 and Section 88 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. c

15. Sections 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 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.” d

16. 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 304-A IPC can be passed. e

17. 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”. f

18. 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 endotracheal tube of proper size being introduced before the operation and which 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 decomposing g
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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”.

- a 19. 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 endotracheal tube of proper size” and in a manner so as to prevent aspiration of blood blocking respiratory passage.

- b 20. 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. v. Adomako*¹
c relied upon on behalf of the doctor elucidates the said legal position and contains the 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.”

- d 21. 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
e or some degree of want of adequate care and caution might create civil liability but would not suffice to hold him criminally liable.

- f 22. 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 the risk of landing themselves in prison for alleged criminal negligence.

- g 23. 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 the 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.

- h 24. 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

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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 endotracheal 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.

25. 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 wrongdoing* i.e. *a higher degree of morally blameworthy conduct*.

26. 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 the 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.

27. 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 pp. 247-48). 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 wrongdoing, 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

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a conduct, and constitute grounds for compensation and at times, for punishment. Distinguishing between these various categories requires careful, morally sensitive and scientifically informed analysis.”

28. 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 trial for offence under Section 304-A 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 the accused and appellant before us.

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c (BEFORE S.N. VARIAVA AND H.K. SEMA, JJ.)
MAHANAGAR TELEPHONE NIGAM LTD. . . . Appellant;
Versus
CHAIRMAN, CENTRAL BOARD, DIRECT TAXES
AND ANOTHER . . . Respondents.

d Civil Appeal No. 3058 of 2004[†], decided on May 7, 2004

e **A. Constitution of India — Art. 136 — Maintainability — SLP filed by public sector undertaking against Government — Omission to obtain clearance from High-Powered Committee — Effect on maintainability — Government undertaking, although not permitted by the High-Powered Committee, unsuccessfully filing writ petition to challenge show-cause notice from the Revenue and thereafter filing SLP — Such SLP refused to be proceeded with notwithstanding that special leave had already been granted — Further held, the Committee’s decision was eminently fair and correct and intended to prevent frivolous litigation**

f **B. Constitution of India — Arts. 133, 136, 32 and 226 — Disputes between Union of India and its public sector undertakings — High-Powered Committee, as directed by the Supreme Court, set up for resolving such disputes — Objects of, held, not limited to conciliation but include preventing frivolous cases from reaching the courts**

g The appellant herein, a public sector undertaking filed a writ petition before the Delhi High Court challenging a show-cause notice issued by the respondent. The High Court, on merits, decided against the appellant. The appellant then filed the instant SLP. Requesting the Supreme Court not to proceed with the SLP, the Revenue submitted that the High-Powered Committee, established by the Government under the Supreme Court’s order dated 11-9-1991, had advised the appellant herein to await the appealable order and had not permitted it to file the writ petition. The Revenue added that the appellant was bound by the said Committee’s decision. The Revenue further submitted that the final order should be permitted to be passed and the appellant could then have its remedy against

h [†] Arising out of SLP (C) No. 17293 of 2000. From the Judgment and Order dated 24-8-2000 of the Delhi High Court in CWP No. 228 of 2000

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(BEFORE R.C. LAHOTI, C.J. AND G.P. MATHUR
AND P.K. BALASUBRAMANYAN, JJ.)

JACOB MATHEW

.. Appellant;

Versus

d

STATE OF PUNJAB AND ANOTHER

.. Respondents.

Criminal Appeals Nos. 144-45 of 2004[†], decided on August 5, 2005

e

A. Penal Code, 1860 — S. 304-A — Death due to criminal medical negligence — Liability of doctors under — When attracted — Test to be applied — Special treatment of doctors — Rationale for, discussed in detail — Held, it must be shown that accused doctor did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do — Hazard taken by accused doctor should be of such a nature that injury which resulted was most likely imminent — On facts, aged patient in advanced stage of terminal cancer experiencing breathing difficulties about 11 p.m. at night and succumbing due to unavailability of oxygen cylinders with oxygen, which was sought to be administered by appellant-accused doctor — Held, it is a case of non-availability of oxygen cylinders for which hospital may be liable in tort, but appellant cannot be proceeded against under S. 304-A on parameters of *Bolam test*, (1957) 2 All ER 118, 121 D-F [set out in para 19 herein] — Medical Practitioners — Criminal Law — Negligence

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[Ed.: The Supreme Court has made an extensive discussion of the various issues that may arise in cases of *civil* medical negligence as noted under Short Note J. It would seem that all the conclusions in respect thereof would be applicable *mutatis mutandis* to cases of criminal medical negligence, the difference being that all rulings would have to be considered in the context of the *higher* level of negligence necessary to constitute criminal negligence.]

B. Penal Code, 1860 — S. 304-A — Death due to administration of medicine of which knowledge not possessed by doctor, though professed

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[†] From the Judgments and Orders dated 18-12-2002 and 24-1-2003 of the Punjab and Haryana High Court in Crl. Misc. No. 21940-M of 1999 and Crl. Misc. No. 1984 of 2003

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expressly or impliedly, held, prima facie constitutes criminal medical negligence — Medical Practitioners — Medical practice — Criminal Law — Negligence

C. Medical Practitioners — Medical practice — Prosecution of criminal offences against doctors — Detailed guidelines laid down to protect interest of doctors, and to save them from unwarranted and malicious proceedings — Rationale for, discussed in detail — Penal Code, 1860 — Ss. 304-A, 88, 92 and 93 — Constitution of India — Arts. 142 and 141 — Criminal Trial — Doctors — Criminal Procedure Code, 1973 — Ss. 204, 201-203 and 70

D. Penal Code, 1860 — S. 304-A — Nature of negligence required under — Phrase “rash or negligent act” — Scope of — Held, though word “gross” has not been used in S. 304-A, expression “rash and negligent act” in S. 304-A has to be read as qualified by word “grossly” — Reasons for, discussed — Interpretation of Statutes — Subsidiary rules — Casus omissus — Instance of, supplied by court

E. Penal Code, 1860 — S. 304-A — Liability under — When attracted — Held, it is necessary that death should have been the direct result of a rash and negligent act of accused, and that act must be the proximate and efficient cause without the intervention of another’s negligence — It must be the *causa causans* — It is not enough that it may have been the *causa sine qua non* — Criminal Law — Negligence — Causation

On 15-2-1995, the informant’s father, late Jiwan Lal Sharma was admitted as a patient in a private ward of CMC Hospital, Ludhiana. On 22-2-1995 at about 11 p.m., Jiwan Lal felt difficulty in breathing. The complainant’s elder brother, Vijay Sharma who was present in the room contacted the duty nurse, who in her turn called some doctor to attend to the patient. No doctor turned up for about 20 to 25 minutes. Then, Dr. Jacob Mathew, the appellant and Dr. Allen Joseph came to the room of the patient. An oxygen cylinder was brought and connected to the mouth of the patient but the breathing problem increased further. The patient tried to get up but the medical staff asked him to remain in bed. The oxygen cylinder was found to be empty. There was no other gas cylinder available in the room. Vijay Sharma went to the adjoining room and brought a gas cylinder therefrom. However, there was no arrangement to make the gas cylinder functional and in-between, 5 to 7 minutes were wasted. By this time, another doctor arrived who declared that the patient was dead. On the abovesaid report, an offence under Sections 304-A/34 IPC was registered and investigated. On charges having been filed against the two doctors, and their failure to obtain quashment thereof in all the forums below, the appellant was before the Supreme Court by special leave.

Allowing the appeals, the Supreme Court

Held :

Criminal medical negligence

Indiscriminate prosecution of medical professionals for criminal negligence is counter-productive and does no service or good to society. 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

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a 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. (Paras 28, 29 and 47)

b The criminal law has invariably placed medical professionals on a pedestal different from ordinary mortals. The Penal Code enacted as far back as in the year 1860 sets out a few vocal examples, in Sections 88, 92 and 93. (Para 34)

c The word “gross” has not been used in Section 304-A IPC, yet it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be “gross”. The expression “rash or negligent act” as occurring in Section 304-A IPC has to be read as qualified by the word “grossly”. To impose criminal liability under Section 304-A, the Penal Code, it is necessary that the death should have been the direct result of a rash and negligent act of the accused, and that act must be the proximate and efficient cause without the intervention of another’s negligence. It must be the *causa causans*; it is not enough that it may have been the *causa sine qua non*. [Paras 48(6) and 38]

d To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent. [Para 48(7)]

e A doctor who administers a medicine known to or used in a particular branch of medical profession impliedly declares that he has knowledge of that branch of science and if he does not, in fact, possess that knowledge, he is *prima facie* acting with rashness or negligence. (Para 40)

f *Suresh Gupta (Dr.) v. Govt. of NCT of Delhi*, (2004) 6 SCC 422 : 2004 SCC (Cri) 1785, affirmed

John Oni Akerele v. R., AIR 1943 PC 72 : 44 Cri LJ 569; *Kurban Hussein Mohammedali Rangwalla v. State of Maharashtra*, (1965) 2 SCR 622 : (1965) 2 Cri LJ 550; *Kishan Chand v. State of Haryana*, (1970) 3 SCC 904; *Juggankhan v. State of M.P.*, (1965) 1 SCR 14 : (1965) 1 Cri LJ 763, relied on

Emperor v. Omkar Rampratap, (1902) 4 Bom LR 679, held, approved

g *Roscoe’s Law of Evidence* (15th Edn.), pp. 848-49; “*Speeches and Poems with the Report and Notes on the Indian Penal Code*” by Lord Macaulay (Houghton, Mifflin and Company, published in 1874), pp. 419, 421 & 422; Alan Merry and Alexander McCall Smith in their work *Errors, Medicine and the Law* (Cambridge University Press, 2001), pp. 241-248, relied on

h In the present case all the averments made in the complaint, even if held to be proved, do not make out a case of criminal rashness or negligence on the part of the accused-appellant. It is not the case of the complainant that the accused-appellant was not a doctor qualified to treat the patient whom he agreed to treat.

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It is a case of non-availability of oxygen cylinders either because of the hospital having failed to keep available a gas cylinder or because of the gas cylinder being found empty. Then, probably the hospital may be liable in civil law or may be not, but the accused-appellant cannot be proceeded against under Section 304-A IPC on the parameters of the *Bolam test*, (1957) 2 All ER 118, at p. 121 D-F [set out in para 19 herein]. (Para 53) a

Guidelines for prosecuting medical professionals for criminal negligence

The investigating officer and the private complainant cannot always be supposed to have knowledge of medical science so as to determine whether the act of the accused medical professional amounts to a rash or negligent act within the domain of criminal law under Section 304-A IPC. The criminal process once initiated subjects the medical professional to serious embarrassment and sometimes harassment. He has to seek bail to escape arrest, which may or may not be granted to him. At the end he may be exonerated by acquittal or discharge but the loss which he has suffered to his reputation cannot be compensated by any standards. Many a complainant prefer recourse to criminal process as a tool for pressurising the medical professional for extracting uncalled for or unjust compensation. Such malicious proceedings have to be guarded against. The service which the medical profession renders to human beings is probably the noblest of all, and hence there is a need for protecting doctors from frivolous or unjust prosecutions. (Paras 50 and 51) b

Statutory rules or executive instructions incorporating certain guidelines need to be framed and issued by the Government of India and/or the State Governments in consultation with the Medical Council of India. So long as it is not done, the following guidelines will be in force which shall govern the prosecution of doctors for offences of which criminal rashness or criminal negligence is an ingredient. A private complaint may 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. 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 and unbiased opinion applying the *Bolam test*, (1957) 2 All ER 118, at p. 121 D-F [set out in para 19 herein], to the facts collected in the investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been levelled 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 may be withheld. (Para 52) c

§F. Penal Code 1860 — S. 304-A — *Res ipsa loquitur* — Nature and scope of — Applicability of the said principle in criminal law — Held, said rule cannot be pressed into service for determining *per se* the liability for negligence in criminal law and case under S. 304-A cannot be decided solely by applying the said rule — Doctrines — Tort — Negligence — Criminal Trial — Appreciation of evidence — Evidence Act, 1872 — S. 114 [Paras 48(8) and 27] d

§ [Ed.: See also Short Note L, below.] e

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Syad Akbar v. State of Karnataka, (1980) 1 SCC 30 : 1980 SCC (Cri) 59, *relied on*
Krishnan v. State of Kerala, (1996) 10 SCC 508 : 1996 SCC (Cri) 1375, *explained*

a **G. Penal Code, 1860 — Ss. 304-A, 88, 92 and 93 — Criminal negligence — When actionable — Held, to hold existence of criminal negligence it shall have to be found that the rashness was of such a degree as to amount to taking a hazard knowing that the hazard was of such a degree that injury was most likely imminent — Criminal Law — Negligence**

b **H. Penal Code, 1860 — Ss. 304-A, 88, 92 and 93 — Criminal negligence — Ingredients of — *Mens rea* in respect of, what is — Nature, scope and instances of, discussed — Held, for negligence to amount to a criminal offence, element of *mens rea* must be shown to exist — Further held, it is recklessness that constitutes the *mens rea* in criminal negligence — Criminal Law — Negligence**

c **I. Penal Code, 1860 — Ss. 304-A, 88, 92 and 93 — Criminal negligence and negligence in tort/civil law — Meanings of — Degrees of negligence — Held, are jurisprudentially different — To fasten liability in criminal law, degree of negligence has to be higher than negligence enough to fasten liability for damages in civil law i.e. gross or of a higher degree — Jurisprudence — Criminal Law — Negligence — Words and phrases — “Criminal negligence”**

d The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. Generally speaking, it is the amount of damages incurred which is determinative of the extent of liability in tort; but in criminal law it is not the amount of damages but the amount and degree of negligence that is determinative of liability. To fasten liability in criminal law, the degree of negligence has to be higher than that of negligence enough to fasten liability for damages in civil law i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution. [Paras 12, 13, 38 and 48(5)]

e While negligence is an omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do; criminal negligence is the *gross and culpable neglect or failure* to exercise that reasonable and proper care and precaution to guard against injury either to the public generally or to an individual in particular, which having regard to all the circumstances out of which the charge has arisen, it was the imperative duty of the accused person to have adopted. A clear distinction exists between “simple lack of care” incurring civil liability and “very high degree of negligence” which is required in criminal cases.

(Paras 16, 14 and 17)

g *Riddell v. Reid*, (1942) 2 All ER 161 : 1943 AC 1 (HL), *relied on*

h For negligence to amount to a criminal offence, the element of *mens rea* must be shown to exist. It is recklessness that constitutes *mens rea* in criminal law as far as negligence is concerned. The moral culpability of recklessness is not located in a desire to cause harm. It resides in the proximity of the reckless state of mind to the state of mind present when there is an intention to cause harm. There is, in other words, a disregard for the possible consequences. The consequences entailed in the risk may not be wanted, and indeed the actor may

hope that they do not occur, but this hope nevertheless fails to inhibit the taking of the risk. Certain types of violation, called optimising violations, may be motivated by thrill-seeking. These are clearly reckless. [Paras 12, 13 and 48(5)]

In order to hold the existence of criminal rashness or criminal negligence it shall have to be found out that the rashness was of such a degree as to amount to taking a hazard knowing that the hazard was of such a degree that injury was most likely imminent. The element of criminality is introduced by the accused having run the risk of doing such an act with recklessness and indifference to the consequences. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment. (Paras 14 and 15)

R. v. Lawrence, (1981) 1 All ER 974 : 1982 AC 510 : (1981) 2 WLR 524 (HL); *R. v. Caldwell*, (1981) 1 All ER 961 : 1982 AC 341 : (1981) 2 WLR 509 (HL); *Andrews v. Director of Public Prosecutions*, 1937 AC 576 : (1937) 2 All ER 552 (HL); *Syad Akbar v. State of Karnataka*, (1980) 1 SCC 30 : 1980 SCC (Cri) 59; *Bhalchandra Waman Pathe v. State of Maharashtra*, 1968 Mah LJ 423 (SC) : 1968 ACJ 38 : 1968 MPLJ 371 (SC),
relied on

Empress of India v. Idu Beg, ILR (1881) 3 All 776 : (1881) 1 AWN 132, *held approved*

J. Tort — Negligence — Medical negligence — When actionable — Test for — Approach to be taken in dealing with cases of — Rationale for differential treatment of medical profession, discussed in extenso — Duties undertaken by doctors enumerated — Held, in a claim of medical negligence, it is enough for defendant to show that standard of care and skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill — Test for medical negligence laid down in *Bolam case*, (1957) 2 All ER 118, 121 D-F [set out in para 19 herein], held, applicable in India — Further explained in detail when deviation from normal medical practice would amount to evidence of medical negligence — Various issues clarified as to (1) state of knowledge by which standard of care is to be determined, (2) standard of care in case of charge of failure (a) to use some particular equipment, or (b) to take some precaution, (3) enquiry to be made when alleged negligence is (a) due to an accident, or (b) due to an error of judgment in choice of a procedure or its execution — Considerations to be kept in mind by any forum trying issue of medical negligence, specified — Medical Practitioners

K. Tort — Negligence — Professional negligence — When actionable — Test for — Held, a professional may be held liable for negligence either (1) when he was not possessed of the requisite skill which he professed to have possessed, or (2) when he did not exercise, with reasonable competence in the given case, the skill which he did possess — Standard to be applied would be that of an ordinary competent person exercising ordinary skill in that profession — Test for professional negligence laid down in *Bolam case*, (1957) 2 All ER 118, 121 D-F [set out in para 19 herein], held, applicable in India — Professional negligence distinguished from occupational negligence

§L. Tort — Negligence — Medical negligence — Applicability of principle of *res ipsa loquitur* — Held, simply because a patient has not responded favourably to a treatment given by a physician or a surgery has failed, the doctor cannot be held liable per se by applying doctrine of *res ipsa loquitur* — Doctrines — Medical Practitioners

§ [Ed.: See also Short Note F, above.]

Professional negligence

- a* In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or as skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised with reasonable degree of care and caution. He does not assure his client of the result. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100%, for the person operated on. The only assurance which such a professional can give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practising and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is all what the person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence. [Paras 18 and 48(3)]

Medical negligence

- f* The subject of negligence in the context of the medical profession necessarily calls for treatment with a difference. There is a marked tendency to look for a human actor to blame for an untoward event, a tendency which is closely linked with the desire to punish. Things have gone wrong and, therefore, somebody must be found to answer for it. An empirical study would reveal that the background to a mishap is frequently far more complex than may generally be assumed. It can be demonstrated that actual blame for the outcome has to be attributed with great caution. For a medical accident or failure, the responsibility may lie with the medical practitioner, and equally it may not. The inadequacies of the system, the specific circumstances of the case, the nature of human psychology itself and sheer chance may have combined to produce a result in which the doctor's contribution is either relatively or completely blameless. The human body and its working is nothing less than a highly complex machine. Coupled with the complexities of medical science, the scope for misimpressions, misgivings and misplaced allegations against the operator i.e. the doctor, cannot be ruled out. One may have notions of best or ideal practice which are different from the reality of how medical practice is carried on or how the doctor functions in real life. The factors of pressing need and limited resources cannot be ruled out from consideration. Dealing with a case of medical negligence needs a deeper understanding of the practical side of medicine. The purpose of holding a

professional liable for his act or omission, if negligent, is to make life safer and to eliminate the possibility of recurrence of negligence in future. The human body and medical science, both are too complex to be easily understood. To hold in favour of existence of negligence, associated with the action or inaction of a medical professional, requires an in-depth understanding of the working of a professional as also the nature of the job and of errors committed by chance, which do not necessarily involve the element of culpability. (Paras 31 and 30)

Negligence in the context of the medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. The classical statement of law in *Bolam case*, (1957) 2 All ER 118, at p. 121 D-F [set out in para 19 herein], has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular, and holds good in its applicability in India. In tort, it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. It is not necessary for every professional to possess the highest level of expertise in that branch which he practises. Three things are pertinent to be noted. Firstly, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time (that is, the time of the incident) on which it is suggested as should have been used. Thirdly, when it comes to the failure of taking precautions, what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. [Paras 48(2), 48(4), 19 and 24)

A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for that purpose. Such a person when consulted by a patient owes him certain duties viz. a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to be given or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. 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. The doctor no doubt has a discretion in choosing the treatment which he proposes to give to the patient and such discretion is relatively ampler in cases of an emergency.

(Para 41)

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Let it also be noted that a mere accident is not evidence of negligence. "Accident" during the course of medical or surgical treatment has a wider meaning. Care has to be taken to see that the result of an accident which is exculpatory may not persuade the human mind to confuse it with the consequence of negligence. So also an error of judgment on the part of a professional is not negligence *per se*. An error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care, might have made, then it is not negligence. Higher the acuteness in emergency and higher the complication, 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 he has to choose the lesser evil. The medical professional 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. 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. So long as it can be found that the procedure which was in fact adopted was one which was acceptable to medical science as on that date, the medical practitioner cannot be held negligent merely because he chose to follow one procedure and not another and the result was a failure. (Paras 25, 33 and 45)

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. It is also not enough to show that there is a body of competent professional opinion which considers that the decision of the defendant professional was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. It is also not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken, it was reasonable, in the sense that a responsible body of medical opinion would have accepted it as proper. (Paras 21, 23 and 25)

No sensible professional would intentionally commit an act or omission which would result in loss or injury to the patient as the professional reputation of the person is at stake. A single failure may cost him dear in his career. Even in civil jurisdiction, the rule of *res ipsa loquitur* is not of universal application and has to be applied with extreme care and caution to the cases of professional negligence and in particular that of the doctors. Else it would be counter-productive. Simply because a patient has not favourably responded to a treatment given by a physician or a surgery has failed, the doctor cannot be held liable *per se* by applying the doctrine of *res ipsa loquitur*. (Para 26)

At least three weighty considerations can be pointed out which any forum trying the issue of medical negligence in any jurisdiction must keep in mind. These are: (i) that legal and disciplinary procedures should be properly founded on firm, moral and scientific grounds; (ii) that patients will be better served if the

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real causes of harm are properly identified and appropriately acted upon; and (iii) that many incidents involve a contribution from more than one person, and the tendency is to blame the last identifiable element in the chain of causation, the person holding the “smoking gun”. (Para 32) a

Maynard v. West Midlands Regional Health Authority, (1985) 1 All ER 635 : (1984) 1 WLR 634 (HL); *Hunter v. Hanley*, 1955 SLT 213; *Laxman Balkrishna Joshi v. Trimbak Babu Godbole*, (1969) 1 SCR 206 : AIR 1969 SC 128; *Indian Medical Assn. v. V.P. Shantha*, (1995) 6 SCC 651; *Poonam Verma v. Ashwin Patel*, (1996) 4 SCC 332; *Achutrao Haribhau Khodwa v. State of Maharashtra*, (1996) 2 SCC 634; *Spring Meadows Hospital v. Harjol Ahluwalia*, (1998) 4 SCC 39; *Whitehouse v. Jordan*, (1981) 1 All ER 267 : (1981) 1 WLR 246 (HL); *State of Haryana v. Santra*, (2000) 5 SCC 182, *relied on* b

Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD); *Michael Hyde and Associates v. J.D. Williams & Co. Ltd.*, 2001 PNLR 233 (CA); *Eckersley v. Binnie*, (1988) 18 Con LR 1; *Hucks v. Cole*, (1968) 118 New LJ 469, *approved*

Halsbury's Laws of England (4th Edn., Vol. 30, para 35); *Charlesworth & Percy on Negligence* (10th Edn., 2001), paras 8.02, 8.03, 8.04 & 8.110; *Jackson & Powell on Professional Negligence*, 3rd Edn., paras 1-04, 1-05 and 1-56; Merry, Alan and McCall Smith, Alexander: *Errors, Medicine and the Law* (Cambridge University Press, 2001), *relied on* c

Black's Law Dictionary, 7th Edn., *referred to*

M. Tort — Negligence — Ingredients and actionability — Laid down in detail

N. Tort — Negligence — Definition and meaning (jurisprudential and forensic), discussed in extenso — Words and phrases d

The jurisprudential concept of negligence defies any precise definition. In current forensic speech, negligence has three meanings. They are: (i) a state of mind, in which it is opposed to intention; (ii) careless conduct; and (iii) the breach of a duty to take care that is imposed by either common or statute law. All three meanings are applicable in different circumstances but any one of them does not necessarily exclude the other meanings. (Paras 10 and 11) e

Negligence is the breach of a duty caused by 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. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence, as recognised, are three: “duty”, “breach” and “resulting damage”, that is to say: f

(1) the existence of a duty to take care, which is owed by the defendant to the complainant;

(2) the failure to attain that standard of care, prescribed by the law, thereby committing a breach of such duty; and

(3) damage, which is both causally connected with such breach and recognised by the law, has been suffered by the complainant. g

If the claimant satisfies the court on the evidence that these three ingredients are made out, the defendant should be held liable in negligence.

[Paras 10, 11 and 48(1)]

Ratanlal & Dhirajlal: *Law of Torts*, (24th Edn., 2002, edited by Justice G.P. Singh), pp. 441-42; *Charlesworth & Percy on Negligence* (10th Edn., 2001), paras 1.01, 1.23 and 1.24, *followed* h

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O. Consumer Protection Act, 1986 — S. 2(1)(g) & (o) — “Deficiency in service” — Scope — Doctors — Held, expression is very widely defined and provides a forum for redressal of grievances against professionals, including doctors (Para 9)

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D-M/32721/CR

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10. (1985) 1 All ER 635 : (1984) 1 WLR 634 (HL), *Maynard v. West Midlands Regional Health Authority* 20d
11. (1981) 1 All ER 974 : 1982 AC 510 : (1981) 2 WLR 524 (HL), *R. v. Lawrence* 16d-e
- f 12. (1981) 1 All ER 961 : 1982 AC 341 : (1981) 2 WLR 509 (HL), *R. v. Caldwell* 16e
13. (1981) 1 All ER 267 : (1981) 1 WLR 246 (HL), *Whitehouse v. Jordan* 30d
14. (1980) 1 SCC 30 : 1980 SCC (Cri) 59, *Syad Akbar v. State of Karnataka* 17d-e, 22d
15. (1970) 3 SCC 904, *Kishan Chand v. State of Haryana* 28a-b
16. (1969) 1 SCR 206 : AIR 1969 SC 128, *Laxman Balkrishna Joshi v. Trimbak Bapu Godbole* 28e-f, 29h
- g 17. (1968) 118 New LJ 469, *Hucks v. Cole* 20c
18. 1968 Mah LJ 423 (SC) : 1968 ACJ 38 : 1968 MPLJ 371 (SC), *Bhalchandra Waman Pathe v. State of Maharashtra* 17g
19. (1965) 2 SCR 622 : (1965) 2 Cri LJ 550, *Kurban Hussein Mohammedali Rangwalla v. State of Maharashtra* 27f-g
- h 20. (1965) 1 SCR 14 : (1965) 1 Cri LJ 763, *Juggankhan v. State of M.P.* 28b

12	SUPREME COURT CASES	(2005) 6 SCC
21.	(1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD), <i>Bolam v. Friern Hospital Management Committee</i>	19a, 19c, 19d, 21c, 30a, 30f, 33e-f, 35f, 36b
22.	1955 SLT 213, <i>Hunter v. Hanley</i>	20f
23.	AIR 1943 PC 72 : 44 Cri LJ 569, <i>John Oni Akerele v. R.</i>	26h
24.	(1942) 2 All ER 161 : 1943 AC 1 (HL), <i>Riddell v. Reid</i>	17c-d
25.	1937 AC 576 : (1937) 2 All ER 552 (HL), <i>Andrews v. Director of Public Prosecutions</i>	17b-c, 17d-e
26.	(1902) 4 Bom LR 679, <i>Emperor v. Omkar Rampratap</i>	27g
27.	ILR (1881) 3 All 776 : (1881) 1 AWN 132, <i>Empress of India v. Idu Beg</i>	17g

The Judgment of the Court was delivered by

R.C. LAHOTI, C.J.— Ashok Kumar Sharma, Respondent 2 herein filed a first information report with Police Station, Division 3, Ludhiana, whereupon an offence under Section 304-A read with Section 34 of the Indian Penal Code (for short “IPC”) was registered. The gist of the information is that on 15-2-1995, the informant’s father, late Jiwan Lal Sharma was admitted as a patient in a private ward of CMC Hospital, Ludhiana. On 22-2-1995 at about 11 p.m., Jiwan Lal felt difficulty in breathing. The complainant’s elder brother, Vijay Sharma who was present in the room contacted the duty nurse, who in her turn called some doctor to attend to the patient. No doctor turned up for about 20 to 25 minutes. Then, Dr. Jacob Mathew, the appellant before us and Dr. Allen Joseph came to the room of the patient. An oxygen cylinder was brought and connected to the mouth of the patient but the breathing problem increased further. The patient tried to get up but the medical staff asked him to remain in bed. The oxygen cylinder was found to be empty. There was no other gas cylinder available in the room. Vijay Sharma went to the adjoining room and brought a gas cylinder therefrom. However, there was no arrangement to make the gas cylinder functional and in-between, 5 to 7 minutes were wasted. By this time, another doctor came who declared that the patient was dead. The latter part of FIR states (as per the translation in English as filed by the complainant):

“... the death of my father occurred due to the carelessness of doctors and nurses and non-availability of oxygen cylinder and the empty cylinder was fixed on the mouth of my father and his breathing was totally stopped hence my father died. I sent the dead body of my father to my village for last cremation and for information I have come to you. Suitable action be done sd/- ---- As per statement of intimator the death of Jiwan Lal Sharma has occurred due to carelessness of the doctors and nurses concerned and to fit empty gas cylinder.”

On the abovesaid report, an offence under Sections 304-A/34 IPC was registered and investigated. Challan was filed against the two doctors.

2. The Judicial Magistrate First Class, Ludhiana framed charges under Section 304-A IPC against the two accused persons, both doctors. Both of them filed a revision in the Court of Sessions Judge submitting that there was no ground for framing charges against them. The revision was dismissed. The appellant filed a petition in the High Court under Section 482 of the Code of

JACOB MATHEW v. STATE OF PUNJAB (*Lahoti, C.J.*)

13

Criminal Procedure praying for quashing of FIR and all the subsequent proceedings.

- a* 3. It was submitted before the High Court that there was no specific allegation of any act of omission or commission against the accused persons in the entire plethora of documents comprising the challan papers filed by the police against them. The learned Single Judge who heard the petition formed an opinion that the plea raised by the appellant was available to be urged in defence at the trial and, therefore, a case for quashing the charge was not made out. *b* Vide order dated 18-12-2002, the High Court dismissed the petition. An application for recalling the abovesaid order was moved which too was dismissed on 24-1-2003. Feeling aggrieved by these two orders, the appellant has filed these appeals by special leave.

- c* 4. According to the appellant, the deceased Jiwan Lal was suffering from cancer in an advanced stage and as per the information available, he was, in fact, not being admitted by any hospital in the country because of his being a case of cancer at the terminal stage. He was only required to be kept at home and given proper nursing, food, care and solace coupled with prayers. But as *d* is apparent from the records, his sons are very influential persons occupying important positions in the Government. They requested the hospital authorities that come what may, even on compassionate grounds their father may be admitted in the hospital for regulated medical treatment and proper management of diet. It was abundantly made clear to the informant and his other relations who had accompanied the deceased that the disease was of such a nature and had attained such gravity, that peace and solace could only be got at home. But the complainant could prevail over the doctors and hospital management and got the deceased admitted as an in-patient. *e* Nevertheless, the patient was treated with utmost care and caution and given all the required medical assistance by the doctors and paramedical staff. Every conceivable effort was made by all the attending staff comprising doctors and nurses and other paramedicals to give appropriate medical treatment and the whole staff danced attendance on the patient but what was *f* ordained to happen, did happen. The complainant and his relations, who were misguided or were under mistaken belief as to the facts, lodged a police report against the accused persons, wholly unwarranted and uncalled for.

- g* 5. The matter came up for hearing before a Bench of two learned Judges of this Court. Reliance was placed by the appellant on a recent two-Judge Bench decision of this Court in *Suresh Gupta (Dr.) v. Govt. of NCT of Delhi*¹. The Bench hearing this appeal doubted the correctness of the view taken in *Dr. Suresh Gupta case*¹ and vide order dated 9-9-2004 expressed the opinion that the matter called for consideration by a Bench of three Judges. This is how the case has come up for hearing before this Bench.

- h* 6. In *Dr. Suresh Gupta case*¹ the patient, a young man with no history of any heart ailment, was subjected to an operation performed by Dr. Suresh Gupta for nasal deformity. The operation was neither complicated nor

1 (2004) 6 SCC 422 : 2004 SCC (Cri) 1785

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serious. The patient died. On investigation, the cause of death was found 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”. The Bench formed an opinion that this act attributed to the doctor, even if accepted to be true, could be described as an act of negligence as there was lack of due care and precaution. But, the Court categorically held: (SCC p. 430, para 24) a

“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.” b
(emphasis in original)

7. The referring Bench in its order dated 9-9-2004 has assigned two reasons for their disagreement with the view taken in *Dr. Suresh Gupta case*¹ which are as under:

(1) Negligence or recklessness being “gross” is not a requirement of Section 304-A IPC and if the view taken in *Dr. Suresh Gupta case*¹ is to be followed then the word “gross” shall have to be read into Section 304-A IPC for fixing criminal liability on a doctor. Such an approach cannot be countenanced. c

(2) Different standards cannot be applied to doctors and others. In all cases it has to be seen whether the impugned act was rash or negligent. By carrying out a separate treatment for doctors by introducing degrees of rashness or negligence, violence would be done to the plain and unambiguous language of Section 304-A. If by adducing evidence it is proved that there was no rashness or negligence involved, the trial court dealing with the matter shall decide appropriately. But a doctor cannot be placed at a different pedestal for finding out whether rashness or negligence was involved. d
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8. We have heard the learned counsel for the appellant, the respondent State and the respondent complainant. As the question of medical negligence arose for consideration, we thought it fit to issue notice to the Medical Council of India to assist the Court at the time of hearing which it has done. In addition, a registered Society “People for Better Treatment”, Kolkata; the Delhi Medical Council, the Delhi Medical Association and the Indian Medical Association sought for intervention at the hearing as the issue arising for decision is of vital significance for the medical profession. They too have been heard. Mainly, the submissions made by the learned counsel for the parties and the intervenors have centred around two issues: (i) is there a difference in civil and criminal law on the concept of negligence?; and (ii) whether a different standard is applicable for recording a finding of negligence when a professional, in particular, a doctor is to be held guilty of negligence? f
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9. With the awareness in society, and people in general gathering consciousness about their rights, actions for damages in tort are on the h

¹ *Suresh Gupta (Dr.) v. Govt. of NCT of Delhi*, (2004) 6 SCC 422 : 2004 SCC (Cri) 1785

increase. Not only are civil suits filed, the availability of a forum for grievance redressal under the Consumer Protection Act, 1986 having jurisdiction to hear complaints against professionals for “deficiency in service”, which expression is very widely defined in the Act, has given rise to a large number of complaints against professionals, in particular against doctors, being filed by the persons feeling aggrieved. Criminal complaints are being filed against doctors alleging commission of offences punishable under Section 304-A or Sections 336/337/338 IPC alleging rashness or negligence on the part of the doctors resulting in loss of life or injury (of varying degree) to the patient. The present one is such a case. The order of reference has enabled us to examine the concept of “negligence”, in particular “professional negligence”, and as to when and how it does give rise to an action under the criminal law. We propose to deal with the issues in the interests of settling the law.

c *Negligence as a tort*

10. The jurisprudential concept of negligence defies any precise definition. Eminent jurists and leading judgments have assigned various meanings to negligence. The concept as has been acceptable to Indian jurisprudential thought is well stated in the *Law of Torts*, Ratanlal & Dhirajlal (24th Edn., 2002, edited by Justice G.P. Singh). It is stated (at pp. 441-42):

d “Negligence is the breach of a duty caused by 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. Actionable negligence consists in the neglect of the use of ordinary care or skill towards a person to whom the defendant owes the duty of observing ordinary care and skill, by which neglect the plaintiff has suffered injury to his person or property. ... the definition involves three constituents of negligence: (1) A legal duty to exercise due care on the part of the party complained of towards the party complaining the former’s conduct within the scope of the duty; (2) breach of the said duty; and (3) consequential damage. Cause of action for negligence arises only when damage occurs; for, damage is a necessary ingredient of this tort.”

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g 11. According to *Charlesworth & Percy on Negligence* (10th Edn., 2001), in current forensic speech, negligence has three meanings. They are: (i) a state of mind, in which it is opposed to intention; (ii) careless conduct; and (iii) the breach of a duty to take care that is imposed by either common or statute law. All three meanings are applicable in different circumstances but any one of them does not necessarily exclude the other meanings. (para 1.01) The essential components of negligence, as recognised, are three: “duty”, “breach” and “resulting damage”, that is to say:

h (1) the existence of a duty to take care, which is owed by the defendant to the complainant;

(2) the failure to attain that standard of care, prescribed by the law, thereby committing a breach of such duty; and

(3) damage, which is both causally connected with such breach and recognised by the law, has been suffered by the complainant. (para 1.23) a

If the claimant satisfies the court on the evidence that these three ingredients are made out, the defendant should be held liable in negligence. (para 1.24)

Negligence — as a tort and as a crime

12. The term “negligence” is used for the purpose of fastening the defendant with liability under the civil law and, at times, under the criminal law. It is contended on behalf of the respondents that in both the jurisdictions, negligence is negligence, and jurisprudentially no distinction can be drawn between negligence under civil law and negligence under criminal law. The submission so made cannot be countenanced inasmuch as it is based upon a total departure from the established terrain of thought running ever since the beginning of the emergence of the concept of negligence up to the modern times. Generally speaking, it is the amount of damages incurred which is determinative of the extent of liability in tort; but in criminal law it is not the amount of damages but the amount and degree of negligence that is determinative of liability. To fasten liability in criminal law, the degree of negligence has to be higher than that of negligence enough to fasten liability for damages in civil law. The essential ingredient of *mens rea* cannot be excluded from consideration when the charge in a criminal court consists of criminal negligence. In *R. v. Lawrence*² Lord Diplock spoke in a Bench of five and the other Law Lords agreed with him. He reiterated his opinion in *R. v. Caldwell*³ and dealt with the concept of recklessness as constituting *mens rea* in criminal law. His Lordship warned against adopting the simplistic approach of treating all problems of criminal liability as soluble by classifying the test of liability as being “subjective” or “objective”, and said: (All ER p. 982e-f) b
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“Recklessness on the part of the doer of an act does presuppose that there is something in the circumstances that would have drawn the attention of an ordinary prudent individual to the possibility that his act was capable of causing the kind of serious harmful consequences that the section which creates the offence was intended to prevent, and that the risk of those harmful consequences occurring was not so slight that an ordinary prudent individual would feel justified in treating them as negligible. It is only when this is so that the doer of the act is acting ‘recklessly’ if, before doing the act, he either fails to give any thought to the possibility of there being any such risk or, having recognised that there was such risk, he nevertheless goes on to do it.” f
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13. The moral culpability of recklessness is not located in a desire to cause harm. It resides in the proximity of the reckless state of mind to the state of mind present when there is an intention to cause harm. There is, in h

² (1981) 1 All ER 974 : 1982 AC 510 : (1981) 2 WLR 524 (HL)

³ (1981) 1 All ER 961 : 1982 AC 341 : (1981) 2 WLR 509 (HL)

other words, a disregard for the possible consequences. The consequences entailed in the risk may not be wanted, and indeed the actor may hope that they do not occur, but this hope nevertheless fails to inhibit the taking of the risk. Certain types of violation, called optimising violations, may be motivated by thrill-seeking. These are clearly reckless.

14. In order to hold the existence of criminal rashness or criminal negligence it shall have to be found out that the rashness was of such a degree as to amount to taking a hazard knowing that the hazard was of such a degree that injury was most likely imminent. The element of criminality is introduced by the accused having run the risk of doing such an act with recklessness and indifference to the consequences. Lord Atkin in his speech in *Andrews v. Director of Public Prosecutions*⁴ stated: (All ER p. 556 C)

“Simple lack of care such as will constitute civil liability is not enough. For purposes of the criminal law there are degrees of negligence, and a very high degree of negligence is required to be proved before the felony is established.”

Thus, a clear distinction exists between “simple lack of care” incurring civil liability and “very high degree of negligence” which is required in criminal cases. In *Riddell v. Reid*^{4a} (AC at p. 31) Lord Porter said in his speech —

“A higher degree of negligence has always been demanded in order to establish a criminal offence than is sufficient to create civil liability.” (*Charlesworth & Percy, ibid.*, para 1.13)

15. The fore-quoted statement of law in *Andrews*⁴ has been noted with approval by this Court in *Syad Akbar v. State of Karnataka*⁵. The Supreme Court has dealt with and pointed out with reasons the distinction between negligence in civil law and in criminal law. Their Lordships have opined that there is a marked difference as to the effect of evidence viz. the proof, in civil and criminal proceedings. In civil proceedings, a mere preponderance of probability is sufficient, and the defendant is not necessarily entitled to the benefit of every reasonable doubt; but in criminal proceedings, the persuasion of guilt must amount to such a moral certainty as convinces the mind of the Court, as a reasonable man, beyond all reasonable doubt. Where negligence is an essential ingredient of the offence, the negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

16. Law laid down by Straight, J. in the case of *Empress of India v. Idu Beg*⁶ has been held good in cases and noticed in *Bhalchandra Waman Pathe v. State of Maharashtra*⁷ a three-Judge Bench decision of this Court. It has been held that while negligence is an omission to do something which a

4 1937 AC 576 : (1937) 2 All ER 552 (HL)

4a (1942) 2 All ER 161 : 1943 AC 1 (HL)

5 (1980) 1 SCC 30 : 1980 SCC (Cri) 59

6 ILR (1881) 3 All 776 : (1881) 1 AWN 132

7 1968 Mah LJ 423 (SC) : 1968 ACJ 38 : 1968 MPLJ 371 (SC)

reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do; criminal negligence is the *gross and culpable neglect or failure* to exercise that reasonable and proper care and precaution to guard against injury either to the public generally or to an individual in particular, which having regard to all the circumstances out of which the charge has arisen, it was the imperative duty of the accused person to have adopted.

17. In our opinion, the factor of grossness or degree does assume significance while drawing distinction in negligence actionable in tort and negligence punishable as a crime. To be latter, the negligence has to be gross or of a very high degree.

Negligence by professionals

18. In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised with reasonable degree of care and caution. He does not assure his client of the result. A lawyer does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on. The only assurance which such a professional can give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practising and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is all what the person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practises. In *Michael Hyde and Associates v. J.D. Williams & Co. Ltd.*⁸ Sedley, L.J. said that where a profession embraces a range of views as to what is an acceptable standard of conduct, the competence of the defendant is to be judged by the lowest standard that would be regarded as acceptable. (*Charlesworth & Percy, ibid.*, para 8.03.)

- 19.** An oftquoted passage defining negligence by professionals, generally and not necessarily confined to doctors, is to be found in the opinion of
a McNair, J. in *Bolam v. Friern Hospital Management Committee*⁹, WLR at p. 586 in the following words: (All ER p. 121 D-F)

“[W]here 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
b 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.” (*Charlesworth & Percy, ibid.*, para 8.02)

- 20.** The water of *Bolam*⁹ test has ever since flown and passed under
c several bridges, having been cited and dealt with in several judicial pronouncements, one after the other and has continued to be well received by every shore it has touched as neat, clean and a well-condensed one. After a review of various authorities Bingham, L.J. in his speech in *Eckersley v. Binnie*¹⁰ summarised the *Bolam*⁹ test in the following words: (Con LR p. 79)

“From these general statements it follows that a professional man
d 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
e ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession
f would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet.” (*Charlesworth & Percy, ibid.*, para 8.04)

- 21.** The degree of skill and care required by a medical practitioner is so stated in *Halsbury's Laws of England* (4th Edn., Vol. 30, para 35):

“35. The practitioner must bring to his task a reasonable degree of
g 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
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⁹ (1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)

¹⁰ (1988) 18 Con LR 1

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. a

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.” b

The abovesaid three tests have also been stated as determinative of negligence in professional practice by *Charlesworth & Percy* in their celebrated work on *Negligence (ibid., para 8.110)*.

22. In the opinion of Lord Denning, as expressed in *Hucks v. Cole*¹¹ a medical practitioner was not to be held liable simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference of another. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field. c

23. The decision of the House of Lords in *Maynard v. West Midlands Regional Health Authority*¹² by a Bench consisting of five Law Lords has been accepted as having settled the law on the point by holding that it is not enough to show that there is a body of competent professional opinion which considers that the decision of the defendant professional was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken, it was reasonable, in the sense that a responsible body of medical opinion would have accepted it as proper. Lord Scarman who recorded the leading speech with which the other four Lords agreed quoted (at All ER p. 638f) the following words of Lord President (Clyde) in *Hunter v. Hanley*¹³, observing that the words cannot be bettered: (SLT p. 217) d e f

“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....” g

11 (1968) 118 New LJ 469

12 (1985) 1 All ER 635 : (1984) 1 WLR 634 (HL)

13 1955 SLT 213

Lord Scarman added: (All ER p. 638g-h)

a “A doctor who professes to exercise a special skill must exercise the ordinary skill of his speciality. Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other, but that is no basis for a conclusion of negligence.”

His Lordship further added that: (All ER p. 639d)

b “[A] judge’s ‘preference’ for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred.”

c 24. The classical statement of law in *Bolam case*⁹ has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been invariably cited with approval before the courts in India and applied as a touchstone to test the pleas of medical negligence. In tort, it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be noted. Firstly, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used.

f 25. A mere deviation from normal professional practice is not necessarily evidence of negligence. Let it also be noted that a mere accident is not evidence of negligence. So also an error of judgment on the part of a professional is not negligence *per se*. Higher the acuteness in emergency and higher the complication, 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 he has to choose the lesser evil. The medical professional 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. 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. So long as it can be found that the procedure which was in

h ⁹ *Bolam v. Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)

fact adopted was one which was acceptable to medical science as on that date, the medical practitioner cannot be held negligent merely because he chose to follow one procedure and not another and the result was a failure. a

26. No sensible professional would intentionally commit an act or omission which would result in loss or injury to the patient as the professional reputation of the person is at stake. A single failure may cost him dear in his career. Even in civil jurisdiction, the rule of *res ipsa loquitur* is not of universal application and has to be applied with extreme care and caution to the cases of professional negligence and in particular that of the doctors. Else it would be counter-productive. Simply because a patient has not favourably responded to a treatment given by a physician or a surgery has failed, the doctor cannot be held liable *per se* by applying the doctrine of *res ipsa loquitur*. b

27. *Res ipsa loquitur*^{††} is a rule of evidence which in reality belongs to the Law of Tort. Inference as to negligence may be drawn from proved circumstances by applying the rule if the cause of the accident is unknown and no reasonable explanation as to the cause is coming forth from the defendant. In criminal proceedings, the burden of proving negligence as an essential ingredient of the offence lies on the prosecution. Such ingredient cannot be said to have been proved or made out by resorting to the said rule (see *Syad Akbar v. State of Karnataka*⁵). Incidentally, it may be noted that in *Krishnan v. State of Kerala*¹⁴ the Court has observed that there may be a case where the proved facts would themselves speak of sharing of common intention and while making such observation one of the learned Judges constituting the Bench has in his concurring opinion merely stated “*res ipsa loquitur*”. Nowhere has it been stated that the rule has applicability in a criminal case and an inference as to an essential ingredient of an offence can be found proved by resorting to the said rule. In our opinion, a case under Section 304-A IPC cannot be decided solely by applying the rule of *res ipsa loquitur*. c

28. 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. d

29. 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 e

†† [Ed.: *Res ipsa loquitur* literally means “the thing speaks for itself”.] f

5 (1980) 1 SCC 30 : 1980 SCC (Cri) 59

14 (1996) 10 SCC 508 : 1996 SCC (Cri) 1375 g

a 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.

b **30.** The purpose of holding a professional liable for his act or omission, if negligent, is to make life safer and to eliminate the possibility of recurrence of negligence in future. The human body and medical science, both are too complex to be easily understood. To hold in favour of existence of negligence, associated with the action or inaction of a medical professional, requires an in-depth understanding of the working of a professional as also the nature of the job and of errors committed by chance, which do not

c necessarily involve the element of culpability.

31. The subject of negligence in the context of the medical profession necessarily calls for treatment with a difference. Several relevant considerations in this regard are found mentioned by Alan Merry and Alexander McCall Smith in their work *Errors, Medicine and the Law* (Cambridge University Press, 2001). There is a marked tendency to look for a

d human actor to blame for an untoward event, a tendency which is closely linked with the desire to punish. Things have gone wrong and, therefore, somebody must be found to answer for it. To draw a distinction between the blameworthy and the blameless, the notion of *mens rea* has to be elaborately understood. An empirical study would reveal that the background to a mishap is frequently far more complex than may generally be assumed. It can be

e demonstrated that actual blame for the outcome has to be attributed with great caution. For a medical accident or failure, the responsibility may lie with the medical practitioner and equally it may not. The inadequacies of the system, the specific circumstances of the case, the nature of human psychology itself and sheer chance may have combined to produce a result in which the doctor's contribution is either relatively or completely blameless.

f The human body and its working is nothing less than a highly complex machine. Coupled with the complexities of medical science, the scope for misimpressions, misgivings and misplaced allegations against the operator i.e. the doctor, cannot be ruled out. One may have notions of best or ideal practice which are different from the reality of how medical practice is carried on or how the doctor functions in real life. The factors of pressing

g need and limited resources cannot be ruled out from consideration. Dealing with a case of medical negligence needs a deeper understanding of the practical side of medicine.

32. At least three weighty considerations can be pointed out which any forum trying the issue of medical negligence in any jurisdiction must keep in mind. These are: (i) that legal and disciplinary procedures should be properly

h founded on firm, moral and scientific grounds; (ii) that patients will be better served if the real causes of harm are properly identified and appropriately

acted upon; and (iii) that many incidents involve a contribution from more than one person, and the tendency is to blame the last identifiable element in the chain of causation, the person holding the “smoking gun”. a

33. Accident during the course of medical or surgical treatment has a wider meaning. Ordinarily, an accident means an unintended and unforeseen injurious occurrence; something that does not occur in the usual course of events or that could not be reasonably anticipated (see *Black’s Law Dictionary*, 7th Edn.). Care has to be taken to see that the result of an accident which is exculpatory may not persuade the human mind to confuse it with the consequence of negligence. b

Medical professionals in criminal law

34. The criminal law has invariably placed medical professionals on a pedestal different from ordinary mortals. The Indian Penal Code enacted as far back as in the year 1860 sets out a few vocal examples. Section 88 in the Chapter on General Exceptions provides exemption for acts not intended to cause death, done by consent in good faith for person’s benefit. Section 92 provides for exemption for acts done in good faith for the benefit of a person without his consent though the acts cause harm to the person and that person has not consented to suffer such harm. There are four exceptions listed in the section which are not necessary in this context to deal with. Section 93 saves from criminality certain communications made in good faith. To these provisions are appended the following illustrations: c

Section 88

“A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under a painful complaint, but not intending to cause Z’s death, and intending, in good faith, Z’s benefit, performs that operation on Z, with Z’s consent. A has committed no offence.” e

Section 92

“(a) Z is thrown from his horse, and is insensible. A, a surgeon, finds that Z requires to be trepanned. A, not intending Z’s death, but in good faith, for Z’s benefit, performs the trepan before Z recovers his power of judging for himself. A has committed no offence. f

* * *

(c) A, a surgeon, sees a child suffer an accident which is likely to prove fatal unless an operation be immediately performed. There is no time to apply to the child’s guardian. A performs the operation in spite of the entreaties of the child, intending, in good faith, the child’s benefit. A has committed no offence.”

Section 93 g

“A, a surgeon, in good faith, communicates to a patient his opinion that he cannot live. The patient dies in consequence of the shock. A has committed no offence, though he knew it to be likely that the communication might cause the patient’s death.”

35. It is interesting to note what Lord Macaulay had himself to say about the Indian Penal Code. We are inclined to quote a few excerpts from his speech to the extent relevant for our purpose from “*Speeches and Poems with* h

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the Report and Notes on the Indian Penal Code” by Lord Macaulay (Houghton, Mifflin and Company, published in 1874):

- a* “Under the provisions of our Code, this case would be very differently dealt with according to circumstances. If A kills Z by administering abortives to her, with the knowledge that those abortives are likely to cause her death, he is guilty of voluntary culpable homicide, which will be voluntary culpable homicide by consent, if Z agreed to run the risk, and murder if Z did not so agree. If A causes miscarriage to Z,
- b* not intending to cause Z’s death, nor thinking it likely that he shall cause Z’s death, but so rashly or negligently as to cause her death, A is guilty of culpable homicide not voluntary, and will be liable to the punishment provided for the causing of miscarriage, increased by imprisonment for a term not exceeding two years. Lastly, if A took such precautions that there was no reasonable probability that Z’s death would be caused, and
- c* if the medicine were rendered deadly by some accident which no human sagacity could have foreseen, or by some peculiarity in Z’s constitution such as there was no ground whatever to expect, A will be liable to no punishment whatever on account of her death, but will of course be liable to the punishment provided for causing miscarriage.
- d* It may be proper for us to offer some arguments in defence of this part of the Code.
- It will be admitted that when an act is in itself innocent, to punish the person who does it because bad consequences, which no human wisdom could have foreseen, have followed from it, would be in the highest degree barbarous and absurd.” (p. 419)
- e* “To punish as a murderer every man who, while committing a heinous offence, causes death by pure misadventure, is a course which evidently adds nothing to the security of human life. No man can so conduct himself as to make it absolutely certain that he shall not be so unfortunate as to cause the death of a fellow-creature. The utmost that he can do is to abstain from every thing which is at all likely to cause death.
- f* No fear of punishment can make him do more than this; and therefore, to punish a man who has done this can add nothing to the security of human life. The only good effect which such punishment can produce will be to deter people from committing any of those offences which turn into murders what are in themselves mere accidents. It is in fact an addition to the punishment of those offences, and it is an addition made in the very worst way.” (p. 421)
- g* “When a person engaged in the commission of an offence causes death by rashness or negligence, but without either intending to cause death, or thinking it likely that he shall cause death, we propose that he shall be liable to the punishment of the offence which he was engaged in committing, superadded to the ordinary punishment of involuntary culpable homicide.
- h*

The arguments and illustrations which we have employed for the purpose of showing that the involuntary causing of death, without either rashness or negligence, ought, under no circumstances, to be punished at all, will, with some modifications, which will readily suggest themselves, serve to show that the involuntary causing of death by rashness or negligence, though always punishable, ought, under no circumstances to be punished as murder.” (p. 422) a

36. The following statement of law on criminal negligence by reference to surgeons, doctors, etc. and unskilful treatment contained in *Roscoe’s Law of Evidence* (15th Edn.) is classic: b

“Where a person, acting as a medical man, &c., whether licensed or unlicensed, is so negligent in his treatment of a patient that death results, it is manslaughter if the negligence was so great as to amount to a crime, and whether or not there was such a degree of negligence is a question in each case for the jury. In explaining to juries the test which they should apply to determine whether the negligence in the particular case amounted or did not amount to a crime, Judges have used many epithets, such as ‘culpable’, ‘criminal’, ‘gross’, ‘wicked’, ‘clear’, ‘complete’. But whatever epithet be used and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.” (pp. 848-49) c

* * *

“Whether he be licensed or unlicensed, if he display gross ignorance, or gross inattention, or gross rashness, in his treatment, he is criminally responsible. Where a person who, though not educated as an accoucheur, had been in the habit of acting as a man-midwife, and had unskilfully treated a woman who died in childbirth, was indicted for the murder, L. Ellenborough said that there was no evidence of murder, but the jury might convict of manslaughter. To substantiate that charge the prisoner must have been guilty of criminal misconduct, arising either from the grossest ignorance or the [most?] criminal inattention. One or other of these is necessary to make him guilty of that criminal negligence and misconduct which is essential to make out a case of manslaughter.” (p. 849) d

A review of Indian decisions on criminal negligence e

37. We are inclined to, and we must — as duty-bound, take note of some of the relevant decisions of the Privy Council and of this Court. We would like to preface this discussion with the law laid down by the Privy Council in *John Oni Akerele v. R.*¹⁵ A duly qualified medical practitioner gave to his patient the injection of sobita which consisted of sodium bismuth tartrate as f

¹⁵ AIR 1943 PC 72 : 44 Cri LJ 569 g

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a given in the British Pharmacopoeia. However, what was administered was an overdose of sobita. The patient died. The doctor was accused of manslaughter, reckless and negligent act. He was convicted. The matter reached in appeal before the House of Lords. Their Lordships quashed the conviction. On a review of judicial opinion and an illuminating discussion on the points which are also relevant before us, what Their Lordships have held can be summed up as under:

b (i) That a doctor is not criminally responsible for a patient's death unless his negligence or incompetence went beyond a mere matter of compensation between subjects and showed such disregard for life and safety of others as to amount to a crime against the State. (AIR p. 75a)

c (ii) That the degree of negligence required is that it should be gross, and that neither a jury nor a court can transform negligence of a lesser degree into gross negligence merely by giving it that appellation. ... There is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime. (AIR p. 75b-c)

d (iii) It is impossible to define culpable or criminal negligence, and it is not possible to make the distinction between actionable negligence and criminal negligence intelligible, except by means of illustrations drawn from actual judicial opinions. (AIR p. 75c-d)

... The most favourable view of the conduct of an accused medical man has to be taken, *for it would be most fatal to the efficiency of the medical profession if no one could administer medicine without a halter round his neck.* (AIR p. 75e) (emphasis supplied)

e Their Lordships refused to accept the view that criminal negligence was proved merely because a number of persons were made gravely ill after receiving an injection of sobita from the appellant coupled with a finding that a high degree of care was not exercised. Their Lordships also refused to agree with the thought that merely because too strong a mixture was dispensed once and a number of persons were made gravely ill, a criminal degree of negligence was proved.

f **38.** The question of degree has always been considered as relevant to a distinction between negligence in civil law and negligence in criminal law. In *Kurban Hussein Mohammedali Rangwalla v. State of Maharashtra*¹⁶ while dealing with Section 304-A IPC, the following statement of law by Sir Lawrence Jenkins in *Emperor v. Omkar Rampratap*¹⁷ was cited with approval: (SCR p. 626 D-E)

g "To impose criminal liability under Section 304-A, Indian Penal Code, it is necessary that the death should have been the direct result of a rash and negligent act of the accused, and that act must be the proximate and efficient cause without the intervention of another's negligence. It

h ¹⁶ (1965) 2 SCR 622 : (1965) 2 Cri LJ 550
¹⁷ (1902) 4 Bom LR 679

must be the *causa causans*; it is not enough that it may have been the *causa sine qua non*.”

39. K.N. Wanchoo, J. (as he then was), speaking for the Court, observed that the abovesaid view of the law has been generally followed by the High Courts in India and was the correct view to take of the meaning of Section 304-A. The same view has been reiterated in *Kishan Chand v. State of Haryana*¹⁸.

40. In *Juggankhan v. State of M.P.*¹⁹ the accused, a registered Homoeopath, administered 24 drops of stramonium and a leaf of dhatura to the patient suffering from guinea worm. The accused had not studied the effect of such substances being administered to a human being. The poisonous contents of the leaf of dhatura were not satisfactorily established by the prosecution. This Court exonerated the accused of the charge under Section 302 IPC. However, on a finding that stramonium and dhatura leaves are poisonous and in no system of medicine, except perhaps the Ayurvedic system, is the dhatura leaf given as cure for guinea worm, the act of the accused who prescribed poisonous material without studying their probable effect was held to be a rash and negligent act. It would be seen that the profession of a Homoeopath which the accused claimed to profess did not permit use of the substance administered to the patient. The accused had no knowledge of the effect of such substance being administered and yet he did so. In this background, the inference of the accused being guilty of a rash and negligent act was drawn against him. In our opinion, the principle which emerges is that a doctor who administers a medicine known to or used in a particular branch of medical profession impliedly declares that he has knowledge of that branch of science and if he does not, in fact, possess that knowledge, he is *prima facie* acting with rashness or negligence.

41. *Laxman Balkrishna Joshi v. Trimbak Babu Godbole*²⁰ was a case under the Fatal Accidents Act, 1855. It does not make a reference to any other decided case. The duties which a doctor owes to his patients came up for consideration. The Court held that a person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for that purpose. Such a person when consulted by a patient owes him certain duties viz. a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to be given or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. 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. The doctor no doubt has a discretion in choosing the treatment which he proposes to give to the

18 (1970) 3 SCC 904

19 (1965) 1 SCR 14 : (1965) 1 Cri LJ 763

20 (1969) 1 SCR 206 : AIR 1969 SC 128

a patient and such discretion is relatively ampler in cases of emergency. In this case, the death of the patient was caused due to shock resulting from reduction of the fracture attempted by doctor *without taking the elementary caution of giving anaesthesia to the patient*. The doctor was held guilty of negligence and liability for damages in civil law. We hasten to add that criminal negligence or liability under criminal law was not an issue before the Court, as it did not arise and hence was not considered.

b **42.** In the year 1996, there are three reported decisions available. *Indian Medical Assn. v. V.P. Shantha*²¹ is a three-Judge Bench decision. The principal issue which arose for decision by the Court was whether a medical practitioner renders “service” and can be proceeded against for “deficiency in service” before a forum under the Consumer Protection Act, 1986. The Court dealt with how a “profession” differs from an “occupation” especially in the context of performance of duties and hence the occurrence of negligence.

c The Court noticed that medical professionals do not enjoy any immunity from being sued in contract or tort (i.e. in civil jurisdiction) on the ground of negligence. However, in the observation made in the context of determining professional liability as distinguished from occupational liability, the Court has referred to authorities, in particular, *Jackson & Powell* and have so stated the principles, partly quoted from the authorities: (SCC pp. 665-66, para 22)

d “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. In devising a rational approach to professional liability which must provide proper protection to the consumer while allowing for the factors mentioned above, the approach of the courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services. (See *Jackson & Powell on Professional Negligence*, 3rd Edn., paras 1-04, 1-05 and 1-56.)”

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g **43.** In *Poonam Verma v. Ashwin Patel*²² a doctor registered as a medical practitioner and entitled to practice in homoeopathy only, prescribed an allopathic medicine to the patient. The patient died. The doctor was held to be negligent and liable to compensate the wife of the deceased for the death of her husband on the ground that the doctor who was entitled to practice in homoeopathy only, was under a statutory duty not to enter the field of any other system of medicine and since he trespassed into a prohibited field and prescribed the allopathic medicine to the patient causing the death, his conduct amounted to negligence *per se* actionable in civil law. *Laxman*

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21 (1995) 6 SCC 651
22 (1996) 4 SCC 332

*Balkrishna Joshi case*²⁰ was followed. Vide para 16, the test for determining whether there was negligence on the part of a medical practitioner as laid down in *Bolam case*⁹ was cited and approved. a

44. In *Achutrao Haribhau Khodwa v. State of Maharashtra*²³ the Court noticed that in the very nature of medical profession, skills differ from doctor to doctor and more than one alternative course of treatment is available, all admissible. Negligence cannot be attributed to a doctor so long as he is performing his duties to the best of his ability and with due care and caution. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession. It was a case where a mop was left inside the lady patient's abdomen during an operation. Peritonitis developed which led to a second surgery being performed on her, but she could not survive. Liability for negligence was fastened on the surgeon because no valid explanation was forthcoming for the mop having been left inside the abdomen of the lady. The doctrine of *res ipsa loquitur* was held applicable "in a case like this". b

45. *Spring Meadows Hospital v. Harjol Ahluwalia*²⁴ is again a case of liability for negligence by a medical professional in civil law. It was held that an error of judgment is not necessarily negligence. The Court referred to the decision in *Whitehouse v. Jordan*²⁵ and cited with approval (at SCC p. 47, para 9) the following statement of law contained in the opinion of Lord Fraser determining when an error of judgment can be termed as negligence: (All ER p. 281b-c) c

"The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care, might have made, then it is not negligence." d

46. In *State of Haryana v. Santra*²⁶ also the *Bolam*⁹ test has been approved. This case too refers to liability for compensation under civil law for the failure of a sterilisation operation performed by a surgeon. We are not dealing with that situation in the case before us and, therefore, leave it to be dealt with in an appropriate case. e

47. Before we embark upon summing up our conclusions on the several issues of law which we have dealt with hereinabove, we are inclined to quote f

20 *Laxman Balkrishna Joshi v. Trimbak Babu Godbole*, (1969) 1 SCR 206 : AIR 1969 SC 128

9 *Bolam v. Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)

23 (1996) 2 SCC 634

24 (1998) 4 SCC 39

25 (1981) 1 All ER 267 : (1981) 1 WLR 246 (HL)

26 (2000) 5 SCC 182 g

a some of the conclusions arrived at by the learned authors[‡] of *Errors, Medicine and the Law* (pp. 241-48), (recorded at the end of the book in the Chapter titled “*Conclusion*”) highlighting the link between moral fault, blame and justice in reference to medical profession and negligence. These are of significance and relevant to the issues before us. Hence we quote:

b (i) The social efficacy of blame and related sanctions in particular cases of deliberate wrongdoings may be a matter of dispute, but their necessity — in principle — from a moral point of view, has been accepted. Distasteful as punishment may be, the social, and possibly moral, need to punish people for wrongdoing, occasionally in a severe fashion, cannot be escaped. A society in which blame is overemphasised may become paralysed. This is not only because such a society will inevitably be backward-looking, but also because fear of blame inhibits the uncluttered exercise of judgment in relations between persons. If we are constantly concerned about whether our actions will be the subject of complaint, and that such complaint is likely to lead to legal action or disciplinary proceedings, a relationship of suspicious formality between persons is inevitable. (*ibid.*, pp. 242-43)

d (ii) Culpability may attach to the consequence of an error in circumstances where sub-standard antecedent conduct has been deliberate, and has contributed to the generation of the error or to its outcome. In case of errors, the only failure is a failure defined in terms of the normative standard of what should have been done. There is a tendency to confuse the reasonable person with the error-free person. While nobody can avoid errors on the basis of simply choosing not to make them, people can choose not to commit violations. A violation is culpable. (*ibid.*, p. 245)

f (iii) Before the court faced with deciding the cases of professional negligence there are two sets of interests which are at stake: the interests of the plaintiff and the interests of the defendant. A correct balance of these two sets of interests should ensure that tort liability is restricted to those cases where there is a real failure to behave as a reasonably competent practitioner would have behaved. An inappropriate raising of the standard of care threatens this balance. (*ibid.*, p. 246) A consequence of encouraging litigation for loss is to persuade the public that all loss encountered in a medical context is the result of the failure of somebody in the system to provide the level of care to which the patient is entitled. The effect of this on the doctor-patient relationship is distorting and will not be to the benefit of the patient in the long run. It is also unjustified to impose on those engaged in medical treatment an undue degree of additional stress and anxiety in the conduct of their profession. Equally, it would be wrong to impose such stress and anxiety on any other person performing a demanding function in society. (*ibid.*, p. 247) While expectations from the professionals must be realistic and the expected

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‡ [Ed.: Alan Merry and Alexander McCall Smith.]

standards attainable, this implies recognition of the nature of ordinary human error and human limitations in the performance of complex tasks. (*ibid.*, p. 247)

(iv) Conviction for any substantial criminal offence requires that the accused person should have acted with a morally blameworthy state of mind. Recklessness and deliberate wrongdoing, are morally 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. In fact, negligence at that level is likely to be indistinguishable from recklessness. (*ibid.*, p. 248)

(v) Blame is a powerful weapon. Its inappropriate use distorts tolerant and constructive relations between people. Distinguishing between (a) accidents which are life's misfortune for which nobody is morally responsible, (b) wrongs amounting to culpable conduct and constituting grounds for compensation, and (c) those (i.e. wrongs) calling for punishment on account of being gross or of a very high degree requires and calls for careful, morally sensitive and scientifically informed analysis; else there would be injustice to the larger interest of the society. (*ibid.*, p. 248) (emphasis supplied)

Indiscriminate prosecution of medical professionals for criminal negligence is counter-productive and does no service or good to society.

Conclusions summed up

48. We sum up our conclusions as under:

(1) Negligence is the breach of a duty caused by 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. The definition of negligence as given in *Law of Torts*, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: "duty", "breach" and "resulting damage".

(2) Negligence in the context of the medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also

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a available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. When it comes to the failure of taking precautions, what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is b judged in the light of knowledge available at the time of the incident, and not at the date of trial. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used.

c (3) A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been d negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.

e (4) The test for determining medical negligence as laid down in *Bolam case*⁹, WLR at p. 586[§] holds good in its applicability in India.

f (5) The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of *mens rea* must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.

g (6) The word “gross” has not been used in Section 304-A IPC, yet it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be “gross”. The expression “rash or negligent act” as occurring in Section 304-A IPC has to be read as qualified by the word “grossly”.

h ⁹ *Bolam v. Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)

§ [Ed.: Also at All ER p. 121 D-F and set out in para 19, p. 19 herein.]

(7) To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent. a

(8) *Res ipsa loquitur* is only a rule of evidence and operates in the domain of civil law, specially in cases of torts and helps in determining the onus of proof in actions relating to negligence. It cannot be pressed in service for determining *per se* the liability for negligence within the domain of criminal law. *Res ipsa loquitur* has, if at all, a limited application in trial on a charge of criminal negligence. b

49. In view of the principles laid down hereinabove and the preceding discussion, we agree with the principles of law laid down in *Dr. Suresh Gupta case*¹ and reaffirm the same. *Ex abundanti cautela*, we clarify that what we are affirming are the legal principles laid down and the law as stated in *Dr. Suresh Gupta case*¹. We may not be understood as having expressed any opinion on the question whether on the facts of that case the accused could or could not have been held guilty of criminal negligence as that question is not before us. We also approve of the passage^{§§} from *Errors, Medicine and the Law* by Alan Merry and Alexander McCall Smith which has been cited with approval in *Dr. Suresh Gupta case*¹ (noted vide para 27 of the Report). c d

Guidelines — Re: prosecuting medical professionals

50. As we have noticed hereinabove that the cases of doctors (surgeons and physicians) being subjected to criminal prosecution are on an increase. Sometimes such prosecutions are filed by private complainants and sometimes by the police on an FIR being lodged and cognizance taken. The investigating officer and the private complainant cannot always be supposed e

¹ *Suresh Gupta (Dr.) v. Govt. of NCT of Delhi*, (2004) 6 SCC 422 : 2004 SCC (Cri) 1785

§§ [Ed.: The following is the said extract from Merry and McCall Smith: *Errors, Medicine and the Law*, cited with approval in *Dr. Suresh Gupta case*, (2004) 6 SCC 422 (at pp. 247-48 of the book): f

“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 wrongdoing, 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. g

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.” h

a to have knowledge of medical science so as to determine whether the act of the accused medical professional amounts to a rash or negligent act within the domain of criminal law under Section 304-A IPC. The criminal process once initiated subjects the medical professional to serious embarrassment and sometimes harassment. He has to seek bail to escape arrest, which may or may not be granted to him. At the end he may be exonerated by acquittal or discharge but the loss which he has suffered to his reputation cannot be compensated by any standards.

b **51.** We may not be understood as holding that doctors can never be prosecuted for an offence of which rashness or negligence is an essential ingredient. All that we are doing is to emphasise the need for care and caution in the interest of society; for, the service which the medical profession renders to human beings is probably the noblest of all, and hence there is a need for protecting doctors from frivolous or unjust prosecutions.
c Many a complainant prefer recourse to criminal process as a tool for pressurising the medical professional for extracting uncalled for or unjust compensation. Such malicious proceedings have to be guarded against.

d **52.** Statutory rules or executive instructions incorporating certain guidelines need to be framed and issued by the Government of India and/or the State Governments in consultation with the Medical Council of India. So long as it is not done, we propose to lay down certain guidelines for the future which should govern the prosecution of doctors for offences of which criminal rashness or criminal negligence is an ingredient. A private complaint may 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. 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 and unbiased opinion applying the *Bolam*⁹ test to the facts collected in the investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been levelled 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 may be withheld.
g

Case at hand

h **53.** Reverting back to the facts of the case before us, we are satisfied that all the averments made in the complaint, even if held to be proved, do not make out a case of criminal rashness or negligence on the part of the

⁹ *Bolam v. Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)

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accused-appellant. It is not the case of the complainant that the accused-appellant was not a doctor qualified to treat the patient whom he agreed to treat. It is a case of non-availability of oxygen cylinder either because of the hospital having failed to keep available a gas cylinder or because of the gas cylinder being found empty. Then, probably the hospital may be liable in civil law (or may not be — we express no opinion thereon) but the accused-appellant cannot be proceeded against under Section 304-A IPC on the parameters of the *Bolam*⁹ test.

Result

54. The appeals are allowed. The prosecution of the accused-appellant under Sections 304-A/34 IPC is quashed.

55. All the interlocutory applications be treated as disposed of.

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(BEFORE ARIJIT PASAYAT AND H.K. SEMA, JJ.)

Civil Appeal No. 7797 of 2003[†]

A.P. STATE ROAD TRANSPORT CORPORATION AND OTHERS .. Appellants;

Versus

ABDUL KAREEM .. Respondent.

With

Civil Appeal No. 37 of 2005

D. SHANKER .. Appellant;

Versus

A.P. SRTC, NIZAMABAD REGION .. Respondent.

Civil Appeals No. 7797 of 2003 with No. 37 of 2005,
decided on August 2, 2005

Labour Law — Reinstatement/Back wages/Arrears — Benefits available to workman as a matter of course on reinstatement — Increments in pay for period of absence — Entitlement to — Held, workman is not entitled to any consequential relief on reinstatement as a matter of course, unless specifically directed by forum granting reinstatement — On facts, there being no such specific direction, merely because workman had been directed to be reinstated without back wages, he could not claim a benefit of increments notionally earned during period of he was out of service — It would be incongruous that a workman, having been held guilty and

⁹ *Bolam v. Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)

[†] From the Judgment and Order dated 31-10-2002 of the Andhra Pradesh High Court in WA No. 1209 of 2002

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(2010) 3 Supreme Court Cases 480

(BEFORE DALVEER BHANDARI AND H.S. BEDI, JJ.)

KUSUM SHARMA AND OTHERS .. Appellants; *a*

Versus

BATRA HOSPITAL AND MEDICAL
RESEARCH CENTRE AND OTHERS .. Respondents.

Civil Appeal No. 1385 of 2001[†], decided on February 10, 2010

A. Consumer Protection — Services — Medical services — Negligence/ Criminal negligence — Tests to determine existence of principles culled out from treatises and case law, laid down — Liability of doctor towards patient explained — Adopting higher risk procedure — When not negligence *b*

— Held, doctor must have a reasonable degree of skill and knowledge — He must also exercise care of a reasonable degree, neither highest nor very low, in the light of the particular circumstances of the case

— He would be liable only where his conduct falls below that of a reasonably competent doctor — Divergence of opinion with other doctors, not by itself sufficient to infer negligence *c*

— Adopting of a procedure involving higher element of risk with bona fide expectation of greater chance of success, in preference to a procedure involving lesser risk but higher chances of failure, although not yielding desired result, held, may not amount to negligence — Removal of malignant abdominal tumour by surgical operation with anterior approach in preference to posterior approach, although failing to save patient from death, held, not indicative of negligence so as to render doctors/hospital liable for compensation — Consumer Protection Act, 1986 — Ss. 2(c), (g) and (o) — Tort Law — Negligence — Medical negligence *d*

B. Consumer Protection — Services — Medical services — Medical negligence — Criminal negligence — Essence of — Held, criminal negligence involves rashness of a degree amounting to taking of a hazard knowing that it was of such a degree that injury was most likely imminent — Element of criminality is introduced by running the risk of doing such act with recklessness and indifference to consequences thereof — Penal Code, 1860 — S. 304-A *e*

C. Consumer Protection — Services — Medical services — Negligence — Concepts of, in civil law and criminal law — Distinction between — Held, “simple lack of care” attracts civil liability whereas “very high degree of negligence” is required in criminal cases — Consumer Protection Act, 1986 — Ss. 2(c), (g) and (o) — Penal Code, 1860 — S. 304-A *f*

D. Consumer Protection — Services — Medical services — Medical negligence — Standard of care — Date on which to be adjudged — Held, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time of incident, and not at the date of trial — Further held, when charge of negligence arises out of failure to use some particular equipment, charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used *g*

[†] From the Judgment and Order dated 30-8-2000 of the National Consumer Disputes Redressal Commission, New Delhi in Original Petition No. 116 of 1991 *h*

Dismissing the appeal, the Supreme Court

Held :

- a* Negligence is the breach of a duty exercised by 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. [Paras 89(I) and 86]
Negligence is an essential ingredient of the offence under Section 304-A IPC. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.
- b* [Paras 89(II) and 86]
The medical professional is expected to bring 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. [Paras 89(III) and 57]
- c* *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1, *reiterated*
Ratanlal & Dhirajlal: Law of Torts, referred to
A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field. [Para 89(IV)]
- d* In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctors. [Para 89(V)]
The medical professional 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. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence. [Para 89(VI)]
Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession. [Para 89(VII)]
- f* The present case is concerned with criminal negligence. To determine the same, the question that needs to be determined is whether the rashness was of such a degree as to amount to taking a hazard knowing that the hazard was of such a degree that injury was most likely imminent. The element of criminality is introduced by the accused having run the risk of doing such an act with recklessness and indifference to the consequences. (Para 62)
- g* *R. v. Lawrence*, 1982 AC 510 : (1981) 2 WLR 524 : (1981) 1 All ER 974 (HL); *Metropolitan Police Commr. v. Caldwell*, 1982 AC 341 : (1981) 2 WLR 509 : (1981) 1 All ER 961 (HL), *followed*
To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent. (Para 87)
- h*

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Achutrao Haribhau Khodwa v. State of Maharashtra, (1996) 2 SCC 634; *Spring Meadows Hospital v. Harjol Ahluwalia*, (1998) 4 SCC 39; *Whitehouse v. Jordan*, (1981) 1 WLR 246 : (1981) 1 All ER 267 (HL); *C.P. Sreekumar (Dr.) v. S. Ramanujam*, (2009) 7 SCC 130, *relied on*

a

A clear distinction exists between “simple lack of care” incurring civil liability and “very high degree of negligence” which is required in criminal cases. (Para 63)

Andrews v. Director of Public Prosecutions, 1937 AC 576 : (1937) 2 All ER 552 (HL); *Syad Akbar v. State of Karnataka*, (1980) 1 SCC 30 : 1980 SCC (Cri) 59; *Bhalchandra v. State of Maharashtra*, AIR 1968 SC 1319 : 1968 Cri LJ 1501, *relied on*

b

Potts (or Riddell) v. Reid, 1943 AC 1, *cited*

Charlesworth & Percy on Negligence (10th Edn., 2001), Para 1.13, *referred to*

To defend himself against a charge of medical negligence it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that in the present case the respondent charged with negligence acted in accordance with the general and approved practice is enough to clear him of the charge. Two things are pertinent. Firstly, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used. (Para 72)

c

d

Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582 : (1957) 2 All ER 118, *explained*

A mere deviation from normal professional practice is not necessarily evidence of negligence. (Para 73)

Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582 : (1957) 2 All ER 118; *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369; *Eckersley v. Binnie*, (1988) 18 Con LR 1; *Hucks v. Cole*, (1968) 118 New LJ 469; *Maynard v. West Midlands Regl. Health Authority*, (1984) 1 WLR 634 : (1985) 1 All ER 635 (HL); *Hunter v. Hanley*, 1955 SLT 213, *relied on*

e

Michael Hyde and Associates v. J.D. Williams & Co. Ltd., 2001 PNLR 233 (CA), *cited*

Charlesworth & Percy on Negligence (10th Edn., 2001), Paras 8.03, 8.04; *Halsbury's Laws of England* (4th Edn., Vol. 30, para 35), *referred to*

The medical texts speak of both the approaches for adrenalectomy as adopted in the present case. Nowhere has the appellant been able to support her contention that posterior approach was the only possible and proper approach and Respondent 3 was negligent in adopting the anterior approach. (Para 18)

f

Peritoneum, Retroperitoneum and Mesentery, Section IV; *Principles of Surgery*, 18th Edn., p. 560; Clive S. Grant and Jon A. Van Heerden: *Technical Aspects of Adrenalectomy*, Ch. 35, *referred to*

g

Dr. K, Respondent 3 who performed the operation had reasonable degree of skill and knowledge. In the instant case, expert opinion is in favour of the procedure adopted by Respondent 3 at the time of surgery. The test is the standard of ordinary skilled man exercising and professing to have that special skill. (Paras 54 and 57)

Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582 : (1957) 2 All ER 118; *Whitehouse v. Jordan*, (1981) 1 WLR 246 : (1981) 1 All ER 267 (HL); *Chin Keow v. Govt. of Malaysia*, (1967) 1 WLR 813 (PC), *relied on*

h

KUSUM SHARMA v. BATRA HOSPITAL

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Roe v. Minister of Health, (1954) 2 QB 66 : (1954) 2 WLR 915 : (1954) 2 All ER 131 (CA), approved

- a *State of Haryana v. Santra*, (2000) 5 SCC 182, distinguished
Poonam Verma v. Ashwin Patel, (1996) 4 SCC 332, considered
Halsbury's Laws of England, 4th Edn., Vol. 26 pp. 17-18, referred to
70 *Corpus Juris Secundum* (1951) 952, 953, Para 44; *Black's Law Dictionary*, cited

Therefore, it has to be held that the appellants have failed to make out any case of medical negligence against the respondents. The National Commission was justified in dismissing the complaint of the appellants. (Paras 91 and 92)

- b **E. Consumer Protection — Services — Medical services — Claim of medical negligence — Duty of courts to protect medical practitioners acting in good faith against unnecessary harassment, emphasised — Marked tendency on part of complainants to look for a human factor to blame the doctor after happening of an untoward event, taken judicial notice of — Attention drawn to protection afforded by Ss. 88, 92 and 370 IPC, to**
c **professionals, particularly medical professionals — Consumer Protection Act, 1986 — Ss. 2(c), (g) and (o) — Criminal Law — Negligence — Penal Code, 1860 — Ss. 88, 92, 370 and 304-A — Evidence Act, 1872 — Ss. 56 and 57**

Held :

- d Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. One cannot take the benefits without taking risks. (Para 47)

Roe v. Minister of Health, (1954) 2 QB 66 : (1954) 2 WLR 915 : (1954) 2 All ER 131 (CA), relied on

- e Doctors in complicated cases have to take a chance even if the rate of survival is low. The professional should be held liable for his act or omission, if negligent; is to make life safer and to eliminate the possibility of recurrence of negligence in future. But, at the same time courts have to be extremely careful to ensure that unnecessarily professionals are not harassed or they will not be able to carry out their professional duties without fear. (Para 77)

Jacob Mathew v. State of Punjab, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369, followed

- f It is a matter of common knowledge that after happening of some unfortunate event, there is a marked tendency to look for a human factor to blame for an untoward event, a tendency which is closely linked with the desire to punish. Things have gone wrong and, therefore, somebody must be found to answer for it. A professional deserves total protection. The Penal Code has taken care to ensure that people who act in good faith should not be punished. Sections 88, 92 and 370 IPC give adequate protection to the professionals and particularly medical professionals. (Para 78)

- g *John Oni Akerele v. R.*, AIR 1943 PC 72; *Kurban Hussein Mohamedalli Rangawalla v. State of Maharashtra*, AIR 1965 SC 1616 : (1965) 2 Cri LJ 550 : (1965) 2 SCR 622, relied on

Emperor v. Omkar Rampratap, (1902) 4 Bom LR 679, approved

Laxman Balkrishna Joshi (Dr.) v. Dr. Trimbak Babu Godbole, AIR 1969 SC 128, distinguished on facts

Indian Medical Assn. v. V.P. Shantha, (1995) 6 SCC 651, considered

- h *Jackson and Powell on Professional Negligence*, 3rd Edn., Paras 1-04,1-05 and 1-56, cited

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It would not be conducive to the efficiency of the medical profession if no doctor could administer medicine without a halter round his neck.

[Para 89(VIII)]

It is our bounden duty and obligation of the civil society to ensure that medical professionals are not unnecessarily harassed or humiliated so that they can perform their professional duties without fear and apprehension.

[Para 89(IX)]

Medical practitioners at times also have to be saved from such a class of complainants who use the criminal process as a tool for pressurising medical professionals/hospitals, particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be quashed against the medical practitioners.

[Para 89(X)]

Medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for medical professionals.

[Para 89(XI)]

However, the Court should not be understood to have held that doctors can never be prosecuted for medical negligence. As long as doctors have performed their duties and exercised an ordinary degree of professional skill and competence, they cannot be held guilty of medical negligence. It is imperative that doctors must be able to perform their professional duties with free mind.

(Para 90)

H-D/A/45406/CR

Advocates who appeared in this case :

Gp. Capt. Karan Singh Bhati, Ms Aishwarya Bhati, Himanshu Singh and Ms Rekha Giri, Advocates, for the Appellants;

Manvendra Verma, Sudhir Vats, Sanveer Mehalwal (for Ms Kamakshi S. Mehlwal), Parmanand Gaur (NP), Sudhir Kr. Gupta (NP), Somnath Mukherjee (NP) and Ankit Gupta (for Maninder Singh), Advocates, for the Respondents.

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- b 20. (1957) 1 WLR 582 : (1957) 2 All ER 118, *Bolam v. Friern Hospital Management Committee* 494b-c, 494c-d, 495f, 495f-g, 496a-b, 496e, 499f, 499f-g, 500a, 501d-e
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26. (1902) 4 Bom LR 679, *Emperor v. Omkar Rampratap* 503e

The Judgment of the Court was delivered by

d **DALVEER BHANDARI, J.**— This appeal is directed against the judgment and order dated 30-8-2000 passed by the National Consumer Disputes Redressal Commission, New Delhi (for short “the National Commission”) in Original Petition No. 116 of 1991.

e **2.** The appellants filed a complaint under Section 21 of the Consumer Protection Act, 1986 claiming compensation of Rs 45 lakhs attributing deficiency in services and medical negligence in the treatment of the deceased, Shri R.K. Sharma (who was the husband of Appellant 1, Kusum Sharma and the father of Appellants 2 and 3).

f **3.** Brief facts which are necessary to dispose of this appeal are as under: late Shri R.K. Sharma was a Senior Operations Manager in Indian Oil Corporation (Marketing Division). In June 1989, he developed blood pressure. He was very obese. He complained of swelling and breathlessness while climbing stairs. He visited Mool Chand Hospital on 10-12-1989 but no diagnosis could be made. Indian Oil Corporation referred him to Batra Hospital on 14-3-1990 where he was examined by Dr. R.K. Mani, Respondent 2 and Dr. S. Arora who advised him to get admitted for anasarca (swelling).

g **4.** On 18-3-1990 Shri Sharma was admitted in Batra Hospital. On 20-3-1990 an ultrasound of abdomen was done and the next day i.e. on 21-3-1990 a CT scan of abdomen was done and it was found that there was a smooth surface mass in the left adrenal measuring 4.5 x 5 cm and that the right adrenal was normal. Surgery became imperative for removing the left adrenal. The deceased, Shri Sharma and Appellant 1 were informed by h Dr. Mani, Respondent 2 that it was a well-encapsulated benign tumour of the

left adrenal of less than 5 cm in size which could be taken out by an operation. It was decided to carry out the surgical operation for the removal of abdominal tumour.

a

5. On 2-4-1990 the doctor obtained consent from the appellants for the operation of removal of abdominal tumour. On test, the tumour was found to be malignant. The treatment for malignancy by way of administering mitotane could not be given as it was known to have side-effects. The surgery was carried out on 2-4-1990 by Dr. Kapil Kumar, Respondent 3. During the surgery, the body of the pancreas was damaged which was treated and a drain was fixed to drain out the fluids. According to the appellants, considerable pain, inconvenience and anxiety were caused to the deceased and the appellants as the flow of fluids did not stop.

b

6. After another expert consultation with Dr. T.K. Bose, Respondent 4 a second surgery was carried out on 23-5-1990 in Batra Hospital by Dr. Bose assisted by Dr. Kapil Kumar. Shri Sharma was fitted with two bags to drain out the fluids and in due course, wounds were supposed to heal inside and the fluid was to stop. The deceased was discharged on 23-6-1990 carrying two bags on his body, with an advice to follow-up and for change of the dressing. The deceased next visited Batra Hospital only on 31-8-1990 and that too to obtain a medical certificate from Dr. Mani, Respondent 2.

c

7. On 9-10-1990 Shri Sharma vomited at home and arrangements for shifting him to Batra Hospital were made and the hospital's ambulance sent by Dr. Mani. Shri Sharma died in the hospital on 11-10-1990 on account of "pyogenic meningitis".

d

8. It is pertinent to mention that after the discharge from Batra Hospital on 23-6-1990, the deceased wrote a letter on 26-6-1990 to his employer narrating the agony and the pain he underwent at the hands of the doctors in Batra Hospital.

e

9. The deceased, on the suggestion of Dr. Bose, Respondent 4 visited Modi Hospital on 10-7-1990 where Dr. Bose was a Consulting Surgeon for change of dressing after 17 days. Respondents 2 and 3, namely, Dr. Mani and Dr. Kapil Kumar visited the residence of the deceased on 14-7-1990 and found him in a bad condition and asked him to go to AIIMS where he was admitted on 22-7-1990 and treatment was given for pancreatic fistula and chronic fistula. He was discharged on 26-7-1990 with an advice to follow-up in the OPD. The deceased again went to Mool Chand Hospital on 17-8-1990 with pancreatic and faecal fistula which was dressed. The deceased was discharged from Mool Chand Hospital on 31-8-1990.

f

10. The deceased went to Jodhpur on 29-9-1990 and on 30-9-1990 he had to be admitted in Mahatma Gandhi Hospital at Jodhpur where he was diagnosed with having post-operative complications of adrenalectomy and gluteal abscess. The deceased was discharged from there on 3-10-1990 with an advice to get further treatment at AIIMS and when the deceased again went to AIIMS on 8-10-1990, Dr. Kuchupillai, a senior doctor at AIIMS wrote on a slip "to be discussed in the Endosurgical Conference on 8-10-1990".

g

h

11. The appellants after the death of Shri Sharma filed a complaint under Section 21 of the Consumer Protection Act, 1986 before the National Commission claiming compensation attributing deficiency in services and medical negligence in the treatment of the deceased Shri Sharma. The appellants attributed death of Shri Sharma because of negligence of the doctors and the hospital. The appellants alleged that the informed consent was completely lacking in this case. The appellants also alleged that the only tests done before operation to establish the nature of tumour were ultrasound and CT scan which clearly showed a well-encapsulated tumour of the size 4.5 x 5 cm in the left adrenal and the right adrenal was normal.

12. The appellants alleged that the deceased Shri Sharma had no access whatsoever to any of the hospitals records before filing the complaint. The appellants also alleged that there was nothing on record to conclusively establish malignancy of the tumour before the operation was undertaken. The appellants also had the grievance that they were not told about the possible complications of the operation. They were told that it was a small and specific surgery, whereas, the operation lasted for six hours.

13. The appellants alleged that pancreatic abscess was evident as a result of pancreatic injury during surgery. The appellants further alleged that there was nothing on record to show that Dr. Kapil Kumar, Respondent 3 possessed any kind of experience and skill required to undertake such a complicated operation. The appellants also had the grievance that they were not informed in time of the damage caused to the body of pancreas and the removal of the spleen.

14. According to the appellants, the “anterior” approach adopted at the time of first surgery was not the correct approach. Surgery should have been done by adopting “posterior” approach for removal of left adrenal tumour. Dr. Kapil Kumar, Respondent 3 after the first operation on 2-4-1990 told the appellants that the operation was successful and the tumour was completely removed which was in one piece, well defined and no spreading was there. After the surgery, blood was coming out in a tube which was inserted on the left side of the abdomen. On a specific query made by the deceased and Appellant 1, Respondents 2 and 3 told them that the pancreas was perfectly normal but during operation on 2-4-1990 it was slightly damaged but repaired instantly, hence there was no cause of any anxiety. When the fact of damage to pancreas came to the notice of the deceased, he asked for the details which were not given. The appellants alleged that the tumour taken out from the body was not malignant.

15. The complaint of the appellants was thoroughly examined and dealt with by the National Commission. The National Commission had decided the entire case of the appellants in the light of the law which has been crystallised by a number of cases decided by this Court. Some of them have been extensively dealt with by the Commission.

16. The allegations in the complaint were strongly rebutted by Dr. Kapil Kumar, Respondent 3. Dr. Kapil stated in his affidavit that the anterior approach was preferred over the posterior approach in the suspected case of cancer, which was the case of Shri Sharma. The former approach enables the surgeon to look at liver, the aortae area, the general spread and the opposite adrenal gland. The risk involved was explained to the patient and the appellants and they had agreed to the surgery after due consultation with the family doctor.

17. With the help of medical texts in support of adopting “anterior” approach, Respondent 3 mentioned as under:

“(i) ‘The “anterior” approach for adrenalectomy is mandatory whenever optimum exposure is required or when exploration of the entire abdomen is necessary. Therefore, this approach is used in patients with adrenal tumours >4 cm in diameter, or in patients with possibly malignant tumours of any size, such as pheochromocytoma or adrenocortical carcinoma....

Resection of the left adrenal gland requires mobilisation of the spleen and left colon. The lateral peritoneal attachments of the left colon are freed, initially. Then the spleen is scooped out from the left upper guardant medially and the avascular attachments between the spleen and diaphragm are divided. The spleen, stomach, pancreatic tail and left colon are retracted medially en bloc to the superior mesenteric vessels. The left adrenal gland is exposed splendidly in this manner’. (*Peritoneum, Retroperitoneum and Mesentery*, Section IV)

(ii) ‘*Adrenal operations.*—Surgery should be initial treatment for all patients with cushing syndrome secondary to adrenal adenoma or carcinoma. Pre-operative radiologic lateralisation of the tumour allows resection via a unilateral flank incision. Adrenalectomy is curative. Post-operative steroid replacement therapy is necessary until the suppressed gland recovers (3-6 months).

Adrenal carcinoma should be approached via a midline incision to allow radical resection, since surgery is only hope for cure.’ (*Principles of Surgery*, 18th Edn., p. 560)

(iii) ‘Adrenocortical malignancies are rare, often at advanced stage when first discovered and should be approached using an anterior approach to allow adequate exposure of the tumour and surrounding soft tissue and organs’. *Technical Aspects of Adrenalectomy* by Clive S. Grant and Jon A. Van Heerden, Chapter 35.”

18. The medical texts quoted above speak of both the approaches for adrenalectomy. Nowhere Appellant 1 has been able to support her contention that posterior approach was the only possible and proper approach and Respondent 3 was negligent in adopting the anterior approach.

19. Apart from the medical literature, Dr. N.K. Shukla, Additional Professor at AIIMS and a well-known surgeon stated in unequivocal terms in response to a specific question from Appellant 1 that for malignant tumours,

a by and large, we prefer anterior approach. Dr. Nandi, Professor and Head of Department of Gastrointestinal Surgery at AIIMS also supported “anterior” approach and confirmed and reconfirmed adoption of “anterior” approach in view of inherent advantages of the approach.

20. In view of the medical literature and the evidence of eminent doctors of AIIMS, the National Commission did not find any merit in the allegations levelled.

b **21.** According to the appellants, Dr. Bose, Respondent 4, who performed the second surgery on 23-5-1990 did not follow the advice of Dr. Nandi, Professor and Head of Department of Gastrointestinal Surgery at AIIMS. Dr. Nandi had advised placing of feeding tube at a designated place, but this was not done. Dr. Bose, Respondent 4 stated in his affidavit that there are three well-known alternative methods of food supply for nutrition minimising any leakage of enzymes from the pancreas. Any of the alternative methods could be adopted only after opening the stomach and this is precisely what Respondent 4 did i.e. cleared the area of abscess, dead and other infective tissues and inserted a second tube for drainage of fluid in the affected area and in the pancreatic duct. Respondent 4 also inserted a second tube connecting the exterior of the abdomen with the affected part of the pancreas and the abdomen for drainage and clearance in support of the first tube inserted for drainage. According to Respondent 4, this was the best course which could be taken keeping in view the inside status of the stomach of the deceased and that was done.

22. The National Commission did not find any merit in this complaint of the appellants.

e **23.** Another complaint made by the appellants was with regard to “gluteal abscess” which was attributed to “pyogenic meningitis” resulting in the death of Shri Sharma which was first observed in Medical College Hospital at Jodhpur, where the deceased had gone in connection with performing certain rites in connection with the death of his mother-in-law. The gluteal abscess was drained by a simple incision. He was discharged from there on 3-10-1990 with an advice to go to AIIMS, New Delhi and meet Dr. Kuchupillai, the Endocrinologist. According to the doctor, there was not even a whisper of any incision or draining of gluteal abscess. The essentiality certificate makes it clear that no incision was made to drain out gluteal abscess.

24. The appellants aggrieved by the judgment and order of the National Commission filed the present appeal before this Court.

g **25.** This Court issued notice and in pursuance to the notice issued by this Court, a counter-affidavit on behalf of Respondent 1 has been filed by Dr. Ranbir Kumar Gupta. It is mentioned in the affidavit that although the respondents fully sympathised with the appellants’ unfortunate loss, the respondents are constrained to submit that the appellants had presented a malicious, fabricated and distorted account to create a false impression that the respondents were guilty of negligence in treating late Shri R.K. Sharma.

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26. The respondents also submitted that the appellants have ignored the fact that the medicine is not an exact science involving precision and every surgical operation involves uncalculated risks and merely because a complication had ensued, it does not mean that the hospital or the doctor was guilty of negligence. A medical practitioner is not expected to achieve success in every case that he treats. The duty of the doctor like that of other professional men is to exercise reasonable skill and care. The test is the standard of the ordinary skilled man.

27. It is further submitted in the counter-affidavit that the hospital and the doctors attended late Shri Sharma with utmost care, caution and skill and he was treated with total devotion and dedication. Shri Sharma's death was attributable to the serious disease with which he was suffering from. It is also mentioned that the conduct of the deceased himself was negligent when he was discharged on 23-6-1990. The doctors specifically advised him "regular medical follow-up" which the deceased failed to attend. In fact, subsequently, it was Respondent 4 who called upon the deceased and persuaded him to visit Modi Hospital for a change of dressing. The fitness certificate issued to the deceased also bore the endorsement "he would need prolonged and regular follow-up". However, the deceased did not make any effort and was totally negligent.

28. According to the affidavit, the deceased was admitted on 18-3-1990 in Batra Hospital. Dr. R.K. Mani recommended certain investigations such as abdominal ultrasound, echocardiogram, blood tests, etc. On 20-3-1990 Dr. Mani ordered a CT scan of the abdomen for a suspected lump in the abdomen. The CT of abdomen revealed a large left adrenal mass. Accordingly, the following note was recorded by Dr. R.K. Mani in the case-sheet on 21-3-1990:

"CT of abdomen reveals a large left adrenal mass. Evidently there is a secreting adrenal tumour. Patient needs full work up re hormonal status and CT head scan."

The same day Dr. R.K. Mani referred the case to Dr. C.M. Batra, Endocrinologist and sought Dr. Batra's opinion on the diagnosis made by him that anasarca was attributable to the adrenal tumour. Dr. Mani also referred Shri R.K. Sharma to a dermatologist. That after reviewing the case Dr. C.M. Batra agreed with Dr. Mani that anasarca was due to the adrenal tumour. Dr. Batra was also of the opinion that the adrenal tumour could be due to either adrenal or adrenal carcinoma (i.e. cancer). Dr. Batra recommended a CT thorax bone and skeletal survey.

The Dermatologist Dr. Kandhari reported that Shri R.K. Sharma had a fungal infection. After the reports of all the tests and the report of the hormonal assays had been received, Respondent 2 came to a confirmed diagnosis that Shri R.K. Sharma had a secreting adrenal tumour. The patient was informed that surgery for removal of an adrenal tumour was planned. Appellant 1 was also informed that the tumour was suspected to be malignant. Mrs Kusum Sharma told Respondent 2 that one of her relations was a doctor working in Jodhpur Medical College and that she

- would like to consult him. The said relation of Smt Kusum Sharma came down to Delhi, examined Shri R.K. Sharma and went through all the reports. Thereafter, Smt Kusum Sharma gave consent for the surgery. Dr. Kapil Kumar, who specialises in surgical oncology i.e. cancer surgery was asked to operate upon Shri R.K. Sharma. The risk involved in the operation was explained to the petitioner, her husband (now deceased) and their relative and they agreed after due consultation with their family doctor.”
- a*
- b* **29.** Shri Sharma was operated on 2-4-1990 by Dr. Kapil Kumar, Respondent 3 and the adrenal tumour was removed. During surgery it became necessary to remove the spleen of Shri R.K. Sharma. The operation was successful. However, the tail of the pancreas was traumatised during retraction as Shri R.K. Sharma was extremely obese. On examination, the injury to the pancreas was found to be superficial and non-ductal. The damage to the pancreas was repaired immediately with interrupted non-absorbable sutures and drains were placed. The injury to the pancreas was known during surgery and the same was repaired immediately. It was clearly recorded in the operation transcript that the body of the pancreas was damaged on its posterior surface. The said fact was recorded in the discharge summary.
- c*
- d* **30.** It is submitted that after the surgery Shri R.K. Sharma was subjected to ultrasound imaging and sonogram. On 26-4-1990 Respondent 2 ordered a CT scan as he suspected the existence of a pancreatic abscess. The CT scan report was suggestive of peripancreatic inflammation and pancreatic abscess. Thus the CT scan merely confirmed the suspicion of Appellant 1, the wife of Shri R.K. Sharma who was well aware of the injury to the pancreas and the possibility of there being a pancreatic abscess and she had a long discussion with Respondents 2 and 3 regarding the prognosis. It is denied that the patient and the appellants were assured that fluid discharge would stop within 2 or 3 days’ time or that it was a normal complication after any surgery.
- e*
- f* **31.** It is submitted that the tumour mass was sent for biopsy the same day i.e. 2-4-1990. The histopathology report was received the next day and it recorded a positive finding of the tumour being malignant. Since cases of adrenal cancer have a very poor prognosis, six slides were sent to Sir Ganga Ram Hospital for confirmation. The histopathology report from Sir Ganga Ram Hospital also indicated cancer of the adrenal gland.
- g* **32.** It is admitted that due to the insistence of the patient and the appellants to seek expert advice of All India Institute of Medical Sciences the patient was referred to Sir Ganga Ram Hospital for ERCP test. After the CT scan report dated 26-4-1990 confirmed the existence of pancreatic abscess, on 28-4-1990, Respondents 2 and 3 sought the advice of Dr. T.K. Bose, Respondent 4. An ERCP test and sonogram were recommended by Respondent 4 and it was again Respondent 4 who suggested that the opinion of Prof. Nandi of All India Institute of Medical Sciences be sought. ERCP and sonogram are sophisticated tests and the patient can hardly be expected
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to be aware of such procedures. It is submitted that the ERCP test confirmed the initial diagnosis made by Respondents 2 and 3 of there being a leakage from the pancreatic duct and showed the exact site of leakage. Determination of exact site of leakage is one of the principal functions of the ERCP test. a

33. In the counter-affidavit it is specifically denied that the deceased was dissatisfied with the treatment. In the affidavit, it is mentioned that Dr. T.K. Bose and Dr. Kapil Kumar adopted the procedure, which in their opinion was in the best interest of the patient, Shri Sharma.

34. During the second operation on 23-5-1990 it was found that there was matting together of proximal jejunal loops (intestinal loops) in the left infracolic compartment subjacent to root of transverse mesocolon and it was technically hazardous to do feeding jejunostomy. That is why a deviation was made. Dr. T.K. Bose and Dr. Kapil Kumar were not obliged to follow every detail of Dr. Nandi's recommendation as appropriate decisions were to be made in accordance with the findings at surgery. It would be pertinent to point out that Dr. Nandi's note was at best a theoretical analysis whereas Dr. Bose was the man on the spot. Matting of jejunal loops was not known to Dr. Nandi and came to be known only on the operation table. b

35. It is submitted that the bleeding (haematemesis) was due to stress ulceration and not due to damage to the stomach by a nasoduodenal tube. Such bleeding is quite common after a major surgery. It is denied that fundus of the stomach was damaged during surgery or during placement of the nasoduodenal tube as alleged by the appellants. In fact, the site of surgery was nowhere near the fundus of the stomach. It is denied that any procedure adopted by Dr. Bose and Dr. Kapil Kumar in surgery endangered the life of the patient. Shri R.K. Sharma was discharged as his surgical wounds had healed and his overall condition was satisfactory. c

36. It is submitted that after his discharge from Batra Hospital on 23-6-1990, Shri R.K. Sharma did not maintain any contact with the answering respondents till 9-10-1990 barring one visit to Respondent 2 on 31-8-1990 for the purpose of obtaining fitness certificate. The answering respondent cannot be held responsible for any mishap, which might have taken place when the deceased Shri R.K. Sharma was being treated elsewhere. d

37. It is further submitted that no request was received by Respondent 1 from AIIMS for supply of the case-sheets or the tumour mass. Had such a request been received the case-sheets would have been sent to AIIMS forthwith. The tumour mass would also have been sent subject to availability, as generally the mass is not preserved beyond a period of four weeks. As a standard practice, case-sheets are never given to patients as they contain sensitive information which can affect their psyche. e

38. It is submitted that no mala fides can be attributed to the answering respondents for declining the request of Shri R.K. Sharma for handing over the entire mass of tumour. Had the mass been available, it would have definitely been given. As per standard practice, specimens are discarded after one month and, therefore, the tumour mass was not available and as such f

could not be given to Shri R.K. Sharma. All over the world the standard practice is to preserve slides and to use them for review.

a **39.** The histopathology report from Mool Chand Hospital recorded the presence of mitosis, which are indicative of malignancy. The histopathology reports from Batra Hospital and Sir Ganga Ram Hospital clearly indicated the presence of malignancy, whereas the report from Mool Chand Hospital did not specifically indicate whether the tumour was malignant or benign. Rather it was stated in the report that a follow-up was required.

b **40.** It is submitted that pyogenic meningitis was most probably the consequence of gluteal abscess for which the patient had not received any proper treatment in the proceeding weeks. It was only when the patient was in a critical condition that he was brought to Batra Hospital. However, at that stage the disease of the patient was too far advanced.

c **41.** It is denied that pyogenic meningitis “is swelling in the brain due to the spoiled surgery and the unhealed wounds inside caused by the repeated insertions of tubes introducing infections”. It is denied that surgery was spoiled at Batra Hospital. Further when the deceased Shri R.K. Sharma was discharged, all his wounds had healed. Pyogenic meningitis is not swelling of the brain but inflammation of the covering of the brain. It could not have been the consequence of the surgery or the pancreatic abscess.

d **42.** In the discharge summary prepared initially it was recorded specifically that the adrenal mass was malignant and that the patient should be started on mitotane at the earliest after the period of recovery from the operation. However, the appellants had requested Respondent 2 to delete all references about cancer from the discharge slip as her husband was likely to read the same. She apprehended that in such an event her husband would become mentally disturbed. Having regard to the apprehension expressed by Appellant 1 Smt Kusum Sharma, Respondent 2 prepared a fresh discharge summary which did not contain any reference to cancer. The diagnosis of cancer was not an afterthought. The diagnosis of cancer was a considered one after two histopathological reports were received. It is however denied that the patient was told that he was suffering from cancer.

f **43.** It is also denied that Dr. Kapil Kumar lacks experience. On the contrary, Dr. Kapil Kumar has impressive credentials and he had undertaken training in the well known Tata Cancer Hospital at Mumbai and he had adequate experience in handling such operations.

g **44.** The learned counsel appearing for the appellants placed reliance on *Spring Meadows Hospital v. Harjol Ahluwalia*¹ and *Laxman Balkrishna Joshi (Dr.) v. Dr. Trimbak Babu Godbole*². According to Respondent 1, these cases have no application to the present case. The facts in these cases are entirely different and the law of negligence has to be applied according to the facts of the case.

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1 (1998) 4 SCC 39
2 AIR 1969 SC 128

45. According to *Halsbury's Laws of England*, 4th Edn., Vol. 26 pp. 17-18, the definition of negligence is as under:

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

46. In a celebrated and oft cited judgment in *Bolam v. Friern Hospital Management Committee*³ (Queen's Bench Division) McNair, L.J. observed:

(i) a doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art, merely because there is a body of such opinion that takes a contrary view. (*Bolam case*³, WLR p. 587)

“The direction that, where there are two different schools of medical practice, both having recognition among practitioners, it is not negligent for a practitioner to follow one in preference to the other accords also with American law; see 70 *Corpus Juris Secundum* (1951) 952, 953, Para 44. Moreover, it seems that by American law a failure to warn the patient of dangers of treatment is not, of itself, negligence (*ibid.*, 971, Para 48).” (All ER p. 119 A-B)

McNair, L.J. also observed:

Before I turn to that, I must explain what in law we mean by ‘negligence’. In the ordinary case which does not involve any special skill, negligence in law means this: some failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge it by the conduct of the man on the top of a Clapham omnibus. He is the ordinary man. But 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 man exercising and professing to have that special skill. ... A man need not possess the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. (WLR p. 586)

³ (1957) 1 WLR 582 : (1957) 2 All ER 118

a 47. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking risks. Every advancement in technique is also attended by risks.

48. In *Roe v. Minister of Health*⁴ Denning, L.J. said: (QB p. 83)

b "... It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by [unavoidable]* risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way."

c 49. It was also observed in the same case that: (QB pp. 84 & 86-87)

"... We must not look at the 1947 accident with 1954 spectacles. ...

d "... But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure."

e 50. In *Whitehouse v. Jordan*⁵ House of Lords per Lord Edmund-Davies, Lord Fraser and Lord Russell: (WLR p. 258 B & D)

f The test whether a surgeon has been negligent is whether he has failed to measure up in any respect, whether in clinical judgment or otherwise, to the standard of the ordinary skilled surgeon exercising and professing to have the special skill of a surgeon (dictum of McNair, L.J. in *Bolam v. Friern Hospital Management Committee*³, WLR p. 586 : All ER at p. 121).

g 51. In *Chin Keow v. Govt. of Malaysia*⁶ the Privy Council applied these words of McNair, L.J. in *Bolam v. Friern Hospital Management Committee*³: (WLR p. 586)

"... 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,

4 (1954) 2 QB 66 : (1954) 2 WLR 915 : (1954) 2 All ER 131 (CA)

* **Ed.:** The words in the original are "considerable risks".

h 5 (1981) 1 WLR 246 : (1981) 1 All ER 267 (HL)

3 (1957) 1 WLR 582 : (1957) 2 All ER 118

6 (1967) 1 WLR 813 (PC)

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.”

52. This Court in *State of Haryana v. Santra*⁷ in the matter of negligence relied upon *Bolam v. Friern Hospital Management Committee*³ and on *Whitehouse v. Jordan*⁵. a

53. In *Poonam Verma v. Ashwin Patel*⁸ where the question of medical negligence was considered in the context of treatment of a patient, it was observed as under: (SCC p. 348, para 42)

“42. Negligence has many manifestations—it may be active negligence, collateral negligence, comparative negligence, concurrent negligence, continued negligence, criminal negligence, gross negligence, hazardous negligence, active and passive negligence, wilful or reckless negligence or negligence per se....” b

54. In the instant case, Dr. Kapil Kumar, Respondent 3 who performed the operation had reasonable degree of skill and knowledge. According to the findings of the National Commission, he cannot be held guilty of negligence by any stretch of imagination. c

55. Negligence *per se* is defined in *Black’s Law Dictionary* as under:

“*Negligence per se*.—Conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstances, either because it is in violation of a statute or valid municipal ordinance, or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the violation of a public duty, enjoined by law for the protection of person or property, so constitutes.” d

56. In *Bolam v. Friern Hospital Management Committee*³ Lord McNair said: (WLR p. 587) e

“... I myself would prefer to put it this way, : A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.” f

57. In the instant case, expert opinion is in favour of the procedure adopted by Opposite Party 3 at the time of surgery on 2-4-1990. The test is the standard of ordinary skilled man exercising and professing to have that special skill.

58. In *Roe*⁴ Lord Denning said: (QB p. 86)

“... we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong.” g

7 (2000) 5 SCC 182

3 (1957) 1 WLR 582 : (1957) 2 All ER 118

5 (1981) 1 WLR 246 : (1981) 1 All ER 267 (HL)

8 (1996) 4 SCC 332

4 *Roe v. Minister of Health*, (1954) 2 QB 66 : (1954) 2 WLR 915 : (1954) 2 All ER 131 (CA)

a **59.** Other rulings and judgments also hold and support this view. It is on these judgments that the Supreme Court has relied to determine negligence or otherwise.

b **60.** Judgment in *State of Haryana*⁷ in the context of “negligence per se”, is not applicable in the instant case, as herein, there was no violation of public duty enjoined by law. The term “negligence” is used for the purpose of fastening the defendant with liability under the civil law and, at times, under the criminal law. It is contended on behalf of the respondents (*sic* appellants) that in both the jurisdictions, negligence is negligence, and jurisprudentially no distinction can be drawn between negligence under civil law and negligence under criminal law.

c **61.** In *R. v. Lawrence*⁹ Lord Diplock spoke for a Bench of five Judges and the other Law Lords agreed with him. He reiterated his opinion in *Metropolitan Police Commr. v. Caldwell*¹⁰ and dealt with the concept of recklessness as constituting mens rea in criminal law. His Lordship warned against adopting the simplistic approach of treating all problems of criminal liability as soluble by classifying the test of liability as being “subjective” or “objective”, and said: (AC p. 526 F-G)

d “... Recklessness on the part of the doer of an act does presuppose that there is something in the circumstances that would have drawn the attention of an ordinary prudent individual to the possibility that his act was capable of causing the kind of serious harmful consequences that the section which creates the offence was intended to prevent, and that the risk of those harmful consequences occurring was not so slight that an ordinary prudent individual would feel justified in treating them as negligible. It is only when this is so that the doer of the act is acting ‘recklessly’ if before doing the act, he either fails to give any thought to the possibility of there being any such risk or, having recognised that there was such risk, he nevertheless goes on to do it.”

e **62.** We are here concerned with criminal negligence. We have to find out that the rashness was of such a degree as to amount to taking a hazard knowing that the hazard was of such a degree that injury was most likely imminent. The element of criminality is introduced by the accused having run the risk of doing such an act with recklessness and indifference to the consequences.

f **63.** Lord Atkin in his speech in *Andrews v. Director of Public Prosecutions*¹¹, stated: (AC p. 583)

g “... Simple lack of care such as will constitute civil liability is not enough: for purposes of the criminal law there are degrees of negligence: and a very high degree of negligence is required to be proved before the felony is established.”

h ⁷ *State of Haryana v. Santra*, (2000) 5 SCC 182
⁹ 1982 AC 510 : (1981) 2 WLR 524 : (1981) 1 All ER 974 (HL)
¹⁰ 1982 AC 341 : (1981) 2 WLR 509 : (1981) 1 All ER 961 (HL)
¹¹ 1937 AC 576 : (1937) 2 All ER 552 (HL)

Thus, a clear distinction exists between “simple lack of care” incurring civil liability and “very high degree of negligence” which is required in criminal cases. Lord Porter said in his speech in the same case*:

“... A higher degree of negligence has always been demanded in order to establish a criminal offence than is sufficient to create civil liability.”

[*Charlesworth & Percy on Negligence* (10th Edn., 2001), Para 1.13.]

64. The aforementioned statement of law in *Andrews case*¹¹ has been noted with approval by this Court in *Syad Akbar v. State of Karnataka*¹². This Court has dealt with and pointed out with reasons the distinction between negligence in civil law and in criminal law. The Court opined that: (SCC p. 40, para 28)

“28. ... there is a marked difference as to the *effect* of evidence viz. the proof, in civil and criminal proceedings. In civil proceedings, a mere preponderance of probability is sufficient, and the defendant is not necessarily entitled to the benefit of every reasonable doubt; but in criminal proceedings, the persuasion of guilt must amount to such a moral certainty as convinces the mind of the court, as a reasonable man beyond all reasonable doubt. Where negligence is an essential ingredient of the offence, the negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.” (emphasis in original)

65. A three-Judge Bench of this Court in *Bhalchandra v. State of Maharashtra*¹³ has held that while negligence is an omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do:

“9. ... criminal negligence is the *gross and culpable neglect or failure* to exercise that reasonable and proper care and precaution to guard against injury either to the public generally or to an individual in particular, which having regard to all the circumstances out of which the charge has arisen, it was the imperative duty of the accused person to have adopted.” (*Bhalchandra case*¹³, AIR p. 1322, para 9)

(emphasis supplied)

66. This Court in a landmark judgment in *Jacob Mathew v. State of Punjab*¹⁴ while dealing with the case of negligence by professionals also gave illustration of legal profession. The Court observed as under: (SCC p. 18, para 18)

“18. In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing

* **Ed.:** As observed in *Potts (or Riddell) v. Reid*, 1943 AC 1, p. 31.

11 *Andrews v. Director of Public Prosecutions*, 1937 AC 576 : (1937) 2 All ER 552 (HL)

12 (1980) 1 SCC 30 : 1980 SCC (Cri) 59

13 AIR 1968 SC 1319 : 1968 Cri LJ 1501

14 (2005) 6 SCC 1 : 2005 SCC (Cri) 1369

a some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised [and exercised] with reasonable degree of care and caution. He does not assure

b his client of the result. A lawyer does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on. The only assurance which such a professional can give or can be understood to have given by

c implication is that he is possessed of the requisite skill in that branch of profession which he is practising and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is all what the person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of two findings: either he was not

d possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of

e expertise in that branch which he practises. In *Michael Hyde and Associates v. J.D. Williams & Co. Ltd.*¹⁵ Sedley, L.J. said that where a profession embraces a range of views as to what is an acceptable standard of conduct, the competence of the defendant is to be judged by the lowest standard that would be regarded as acceptable.” (*Charlesworth & Percy, ibid.*, Para 8.03.)

f **67.** In *Jacob Mathew case*¹⁴ this Court heavily relied on *Bolam*³. The Court referred to the opinion of McNair, J. (*Bolam case*³, WLR p. 586) defining negligence as under: (*Jacob Mathew case*¹⁴, SCC p. 19, para 19)

g “19. ... [W]here 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-

h ¹⁵ 2001 PNLR 233 (CA)

¹⁴ *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369

³ *Bolam v. Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118

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(2010) 3 SCC

established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.’”

68. In *Eckersley v. Binnie*¹⁶ Bingham, L.J. summarised the *Bolam*³ test in the following words: a

“From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members of his profession in knowledge of new advances, discoveries and developments in his field. He should have such an awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet.” b
(*Charlesworth & Percy, ibid.*, Para 8.04.) c

69. The degree of skill and care required by a medical practitioner is so stated in *Halsbury’s Laws of England* (4th Edn., Vol. 30, Para 35): d

“35. *Degree of skill and care required.*—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. e f

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.” g

70. In *Hucks v. Cole*¹⁷ Lord Denning speaking for the Court observed as under:

“A medical practitioner was not to be held liable simply because things went wrong from mischance or misadventure or through an error

16 (1988) 18 Con LR 1

3 *Bolam v. Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118

17 (1968) 118 New LJ 469

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a of judgment in choosing one reasonable course of treatment in preference of another. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.”

71. In another leading case *Maynard v. West Midlands Regl. Health Authority*¹⁸ the words of Lord President (Clyde) in *Hunter v. Hanley*¹⁹ (SLT p. 217) were referred to and quoted as under: (*Maynard case*¹⁸, WLR p. 638 G-H)

b “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....”

c The Court per Lord Scarman added as under: (*Maynard case*¹⁸, WLR p. 638 H)

d “... a doctor who professes to exercise a special skill must exercise the ordinary skill of his speciality. Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other: but that is no basis for a conclusion of negligence.”

e 72. The ratio of *Bolam case*³ is that it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that the respondent charged with negligence acted in accordance with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be noted. Firstly, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used.

f 73. A mere deviation from normal professional practice is not necessarily evidence of negligence.

g 74. In *Jacob Mathew case*¹⁴ this Court observed that higher the acuteness in emergency and higher the complication, more are the chances of error of judgment. The Court further observed as under: (SCC pp. 21-22, para 25)

“25. ... At times, the professional is confronted with making a choice between the devil and the deep sea and he has to choose the lesser evil.

18 (1984) 1 WLR 634 : (1985) 1 All ER 635 (HL)

h 19 1955 SLT 213

3 *Bolam v. Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118

14 *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369

The medical professional 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. 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. So long as it can be found that the procedure which was in fact adopted was one which was acceptable to medical science as on that date, the medical practitioner cannot be held negligent merely because he chose to follow one procedure and not another and the result was a failure.”

75. A doctor 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.” (*Jacob Mathew case*¹⁴, SCC p. 22, para 28)

76. This Court in *Jacob Mathew case*¹⁴ very aptly observed that: (SCC p. 22, para 28)

“28. ... 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.”

77. Doctors in complicated cases have to take chance even if the rate of survival is low. The professional should be held liable for his act or omission, if negligent; is to make life safer and to eliminate the possibility of recurrence of negligence in future. But, at the same time courts have to be extremely careful to ensure that unnecessarily professionals are not harassed or they will not be able to carry out their professional duties without fear.

78. It is a matter of common knowledge that after happening of some unfortunate event, there is a marked tendency to look for a human factor to blame for an untoward event, a tendency which is closely linked with the desire to punish. Things have gone wrong and, therefore, somebody must be found to answer for it. A professional deserves total protection. The Penal Code, 1860 has taken care to ensure that people who act in good faith should not be punished. Sections 88, 92 and 370 of the Penal Code give adequate protection to the professionals and particularly medical professionals.

79. The Privy Council in *John Oni Akerele v. R.*²⁰ dealt with a case where a doctor was accused of manslaughter, reckless and negligent act and he was convicted. His conviction was set aside by the House of Lords and it was held thus:

14 *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369
20 AIR 1943 PC 72

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KUSUM SHARMA v. BATRA HOSPITAL (*Bhandari, J.*)

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a (i) That a doctor is not criminally responsible for a patient's death unless his negligence or incompetence went beyond a mere matter of compensation between subjects and showed such disregard for life and safety of others as to amount to a crime against the State. (AIR p. 75a-b)

b (ii) That the degree of negligence required is that it should be gross, and that neither a jury nor a court can transform negligence of a lesser degree into gross negligence merely by giving it that appellation. ... There is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime. (AIR p. 75b-c)

c (iii) It is impossible to define culpable or criminal negligence, and it is not possible to make the distinction between actionable negligence and criminal negligence intelligible, except by means of illustrations drawn from actual judicial opinion. ... The most favourable view of the conduct of an accused medical man has to be taken, *for it would be most fatal to the efficiency of the medical profession if no one could administer medicine without a halter round his neck.* (AIR p. 75d-e)

(emphasis supplied)

d In the said case, Their Lordships refused to accept the view that criminal negligence was proved merely because a number of persons were made gravely ill after receiving an injection of sobita from the appellant coupled with a finding that a high degree of care was not exercised. Their Lordships also refused to agree with the thought that merely because too strong a mixture was dispensed once and a number of persons were made gravely ill, a criminal degree of negligence was proved.

e **80.** This Court in *Kurban Hussein Mohamedalli Rangawalla v. State of Maharashtra*²¹, while dealing with Section 304-A IPC, the following statement of law by Sir Lawrence Jenkins in *Emperor v. Omkar Rampratap*²² was cited with approval:

f "To impose criminal liability under Section 304-A, Indian Penal Code, it is necessary that the death should have been the direct result of a rash and negligent act of the accused, and that act must be the proximate and efficient cause without the intervention of another's negligence. It must be the *causa causans*; it is not enough that it may have been the *causa sine qua non*."

81. In *Laxman Balkrishna Joshi (Dr.)*² the Court observed that: (AIR p. 132, para 11)

g "11. ... 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. The doctor no doubt has a discretion in choosing treatment which he proposes to give to the patient and such discretion is relatively ampler in cases of emergency."

h ²¹ AIR 1965 SC 1616 : (1965) 2 Cri LJ 550 : (1965) 2 SCR 622

²² (1902) 4 Bom LR 679

² *Laxman Balkrishna Joshi (Dr.) v. Dr. Trimbak Babu Godbole*, AIR 1969 SC 128

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In that case, the death of patient was caused due to shock resulting from reduction of the fracture attempted by doctor *without taking the elementary caution of giving anaesthetic to the patient*. The doctor was held guilty of negligence and liable for damages in civil law. We hasten to add that criminal negligence or liability under criminal law was not an issue before the Court—as it did not arise and hence was not considered.

82. In a significant judgment in *Indian Medical Assn. v. V.P. Shantha*²³, a three-Judge Bench of this Court held that: (SCC p. 680, para 55)

“55. (1) Service rendered to a patient by a medical practitioner (except where the doctor renders service free of charge to every patient or under a contract of personal service), by way of consultation, diagnosis and treatment, both medicinal and surgical, would fall within the ambit of ‘service’ as defined in Section 2(1)(o) of the [Consumer Protection Act, 1986].”

Deficiency in service has to be judged by applying the test of reasonable skill and care which is applicable in action for damages for negligence.

83. In the said case, the Court also observed as under: (*V.P. Shantha case*²³, SCC pp. 665-66, para 22)

“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. In devising a rational approach to professional liability which must provide proper protection to the consumer while allowing for the factors mentioned above, the approach of the courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services. (See: *Jackson and Powell on Professional Negligence*, 3rd Edn., Paras 1-04,1-05 and 1-56.)”

84. In *Achutrao Haribhau Khodwa v. State of Maharashtra*²⁴ this Court noticed that:

“44. ... in the very nature of medical profession, skills differ from doctor to doctor and more than one alternative course of treatment is available, all admissible. Negligence cannot be attributed to a doctor so long as he is performing his duties to the best of his ability and with due care and caution. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession.”**

23 (1995) 6 SCC 651

24 (1996) 2 SCC 634

** **Ed.:** As observed in *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1, p. 30, para 44.

85. In *Spring Meadows Hospital*¹ the Court observed that an error of judgment is not necessarily negligence. In *Whitehouse*⁵ the Court observed as under: (WLR p. 263 E-F)

a “... The true position is that an error of judgment may, or may not, be negligent, it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant [holds] himself out as having, and acting with ordinary care, then it is [negligence]. If, on the other hand, it is an error that such a man, acting with ordinary care, might have made, then it is not [negligence].”

b **86.** In *Jacob Mathew case*¹⁴ conclusions summed up by the Court were very apt and some portions of which are reproduced hereunder: (SCC p. 32, para 48)

c “48. (1) Negligence is the breach of a duty caused by 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. The definition of negligence as given in *Law of Torts*, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: ‘duty’, ‘breach’ and ‘resulting damage’.

d (2) Negligence in the context of the medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. ...

e (3) ... The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practises. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.”

h ¹ *Spring Meadows Hospital v. Harjol Ahluwalia*, (1998) 4 SCC 39

⁵ *Whitehouse v. Jordan*, (1981) 1 WLR 246 : (1981) 1 All ER 267 (HL)

¹⁴ *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369

87. To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

88. In a relatively recent case in *C.P. Sreekumar (Dr.) v. S. Ramanujam*²⁵ this Court had an occasion to deal with the case of medical negligence in a case in which the respondent was hit by a motorcycle while going on his bicycle and sustained a hairline fracture of the neck of the right femur. Pre-operative evaluation was made and the appellant Dr. Sreekumar, on considering the various options available, decided to perform a hemiarthroplasty instead of going in for the internal fixation procedure. The respondent consented for the choice of surgery after the various options had been explained to him. The surgery was performed the next day. The respondent filed a complaint against the appellant for medical negligence for not opting internal fixation procedure. This Court held that the appellant's decision for choosing hemiarthroplasty with respect to a patient of 42 years of age was not so palpably erroneous or unacceptable as to dub it as a case of professional negligence.

89. On scrutiny of the leading cases of medical negligence both in our country and other countries specially the United Kingdom, some basic principles emerge in dealing with the cases of medical negligence. While deciding whether the medical professional is guilty of medical negligence following well-known principles must be kept in view:

I. Negligence is the breach of a duty exercised by 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.

II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

III. The medical professional is expected to bring 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.

IV. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

V. In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.

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KUSUM SHARMA v. BATRA HOSPITAL (*Bhandari, J.*)

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a VI. The medical professional 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. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

b VII. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession.

c VIII. It would not be conducive to the efficiency of the medical profession if no doctor could administer medicine without a halter round his neck.

d IX. It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessarily harassed or humiliated so that they can perform their professional duties without fear and apprehension.

e X. The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurising the medical professionals/hospitals, particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

f XI. The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals.

g 90. In our considered view, the aforementioned principles must be kept in view while deciding the cases of medical negligence. We should not be understood to have held that doctors can never be prosecuted for medical negligence. As long as the doctors have performed their duties and exercised an ordinary degree of professional skill and competence, they cannot be held guilty of medical negligence. It is imperative that the doctors must be able to perform their professional duties with free mind.

h 91. When we apply well-settled principles enumerated in the preceding paragraphs in dealing with cases of medical negligence, the conclusion becomes irresistible that the appellants have failed to make out any case of medical negligence against the respondents.

92. The National Commission was justified in dismissing the complaint of the appellants. No interference is called for. The appeal being devoid of any merit is dismissed. In view of the peculiar facts and circumstances of this case the parties are directed to bear their own costs.

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Attendants thrash hospital staff after patient's death at Prayagraj hospital

TNN | Apr 23, 2021, 03.36 PM IST



PRAYAGRAJ: Chaos broke out at SRN (Swaroop Rani Nehru) hospital and adjoining areas for more than three hours under the limits of Kotwali police station after attendants of a patient allegedly thrashed an on-duty medical following the death of a patient in wee hours of Friday.

Junior doctors, alongwith para-medical staff sat on a dharna inside the hospital demanding action against the errant attendants. However, dharna was called off after senior police and administrative officials assured action against the errant attendants.

Inspector general of police, Prayagraj range, KP Singh told TOI, "The series of incident started taking place around 3am when an inspector-rank police official named as Zulfiqar, posted at legal cell department in Pratapgarh district, alongwith his brothers had an altercation with a junior doctor following the death of his mother at SRN hospital.

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IG added, "Medical and para-medical staff told senior police officials that the inspector's mother was in a very serious condition

and following her death, the inspector along with two of his brothers had forcibly entered the ward and allegedly thrashed a junior doctor.



IG, however, said the issue went wrong when a medical staff started making video of the altercation between medical staff and attendants and both the parties involved themselves in heated arguments.

The inspector had in fact raised his voice over the filming of a video and both the parties clashed. It took no more time for the

medical and para-medical staff on duty for assembling on the spot and they further sat on a dharna demanding action against the errant attendants.

Senior police and administrative officials along with police forces immediately rushed to the spot and started pacifying the agitating medical and para-medical staff to resume work. The dharna was called off only after senior police and administrative officials assured action against the errant attendants. The errant inspector has also been placed under suspension.

The IG said, "Senior police and administrative officials have been proving the incident through cctv footage and assured the action would be initiated." He, however, said the entry of the inspector along with his brothers inside ward was a wrong step and cases would be registered once the probe was concluded.



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Covid-19 patient's son attacks doctor at Karnataka's Ballari hospital; video goes viral

The incident was caught on a CCTV camera inside the ward and the video went viral on social media sites.



Published: 24th May 2021 05:10 AM | Last Updated: 24th May 2021 05:10 AM

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A clip from CCTV footage at the VIMS Hospital shows the assault on the doctor.

By Kiran Balannanavar

Express News Service

BALLARI: Tension prevailed at VIMS Hospital in Ballari city on Sunday after a woman duty doctor was assaulted by the relative of a Covid patient. The police arrested the attacker soon after. The attacker, Thippeswamy M (33), is seen arguing with the doctor, Dr Priyadarshini, inside the Covid ward and then assaulting her.

The incident was caught on a CCTV camera inside the ward and the video went viral on social media sites. Netizens demanded strict and immediate action against the attacker and also requested better security for doctors fighting the pandemic.

The Cowl Bazar Police, who registered a case, said the attacker’s father, who was being treated for Covid-related issues for a week, died on Sunday morning.

“His father, who was 65-years-old, was admitted to VIMS last week. On Sunday, his relatives blamed hospital authorities for his death and started arguing with the duty doctor. Though Dr Priyadarshini tried to explain to the relatives how the death occurred, the son attacked her,” a police official said.

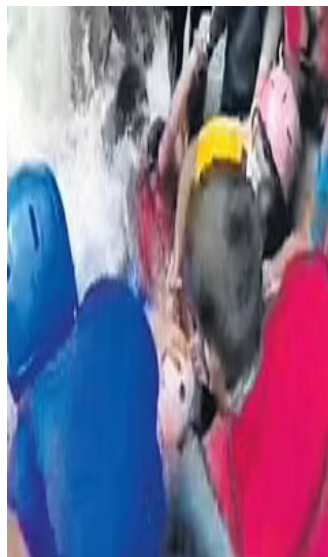
District Health Officer Dr H L Janardhan said, “People should control their emotions. All the doctors and frontline medical staff are working hard to fight the pandemic and such attacks bring down their morale. A case has been registered with the police. We request relatives to reach higher authorities at hospitals, instead of taking law into their hands.”

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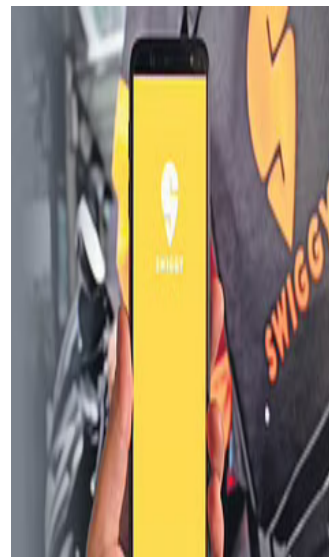
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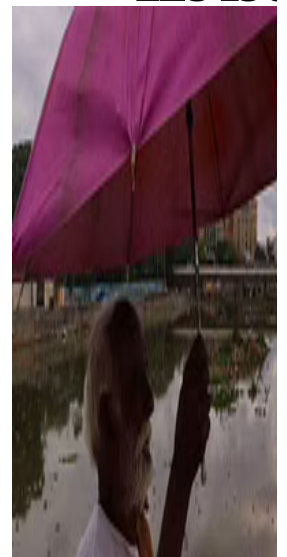
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ANNEXURE: P-8

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Video Shows Injured Karnataka Doctor, 50, Assaulted After Boy's Death

MH Akshay, who is the Superintendent of Police for Chikkamagaluru, told NDTV that Dr Deepak was assaulted on Monday in the district's Tarikere town



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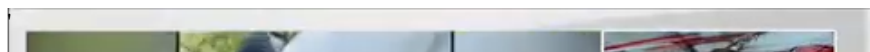
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Bengaluru: Four people have been arrested and charged with attempt to murder following an assault on a 50-year-old doctor earlier this week in Karnataka's Chikkamagaluru district allegedly over the death of a six-year-old patient, the police have said.

Dr Deepak was assaulted on Monday in Chikkamagaluru's Tarikere town, district Superintendent of Police MH Akshay told NDTV. A video shows the injured doctor after the assault.

"Four people from the same taluka were arrested within 18 hours of the crime taking place. Dr Deepak was treating a 6-year-old child, Dhruva, for dengue. After

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Chikkamagaluru: Video Shows Injured Karnataka Doctor, 50, Assaulted After Boy's Death taking place. Dr Deepak was treating a 6-year-old child, Bhuvan, for dengue. After the child developed complications, he was shifted to Shivamogga where he later died. Of the four held, one is the child's relative, the rest are friends," Mr Akshay said

The doctor is receiving treatment in Shivamogga.

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Resident doctors in Karnataka have written to Chief Minister BS Yediyurappa demanding the setting up of a legal cell to deal with such attacks.

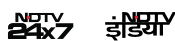
"Doctors across Karnataka are putting their best to bring out best health care facility possible. However it is sad to note that there are more than 12 registered incidents of assault on healthcare workers in the past 8-10 months while the unnoticed, unregistered assaults, and also incidents of verbal abuse, threats, and hampering of duties, can amount to hundreds," reads the letter.

In a similar incident, a doctor at a coronavirus facility in Assam's Hojai, around 140 kilometres from Guwahati, was on Tuesday mercilessly punched, kicked, and pounded with metal trash cans and bricks by the relatives of a Covid patient who had died. Twenty-four people have been arrested in the case.

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MumbaiMirror**ANNEXURE:P-9** **127**

Shocking! COVID-19 patient's relatives stab doctor in Maharashtra's Latur

Mirror Online / Jul 30, 2020, 11.52 AM IST



Latur doctor

In a shocking incident, a senior doctor was assaulted and stabbed by the relatives of the COVID-19 patient in Maharashtra's Latur.

The incident took place at Alpha Superspeciality Hospital in the city at the time when doctors across the state are working round the clock to provide service.

The relatives allegedly attacked the doctor named Dinesh Verma after the patient died in the hospital.



[Maharashtra extends lockdown till August 31: Here's everything that's allowed and not allowed](#)

The notification said that malls and market complexes without theatres, food courts, and restaurants will be operational between 9 am and 7 pm from August 5.

The deceased patient with co-morbidities and had been taking treatment in the hospital for the last few days.

The woman was also suffering from existing chronic ailments due to old age, and the doctor had spoken to the family members about her condition.

However, after her death, an argument took place and the accused stabbed Varma in the chest, neck, and on the hand.

Varma, who is seriously injured, has been admitted to another hospital for treatment. His condition is said to be stable.

Indian Medical Association's local branch has condemned the incident and the president Vishwas Kulkarni has demanded strict action.

Read this story in [Marathi](#)


True Copy

Doctor assaulted after Covid patient dies in Assam

TNN | Jun 1, 2021, 10:14 PM IST



GUWAHATI: A freshly passed out doctor was brutally assaulted by the relatives of a Covid patient who died at a Coronavirus Care Centre in central Assam's Hojai district on Tuesday.

They vented their ire on the doctor, after the critically ill patient died even before he could be shifted out to a hospital. The doctor was severely injured but his condition is said to be stable.

"There people have been arrested in connection to the incident. The doctor has been referred to Nagaon for better treatment," Hojai SP Barun Purkayastha told TOI.

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Chief minister Himanta Biswa Sarma directed police to book the culprits, as medical fraternity condemned the incident in strongest possible words. "Such barbaric attacks on our frontline workers won't be tolerated by our administration," Sarma tweeted, asking Assam police to ensure that the culprits are brought to justice.

Indian Medical Association's (IMA) Assam state branch condemned in all strongest terms the barbaric assault on a freshly passed out doctor Dr. Seuj Kumar Senapati. The medicos' body cautioned the government that the medical fraternity is finding

it extremely difficult to control emotions at this hour of public health emergency.

"IMA and all the doctors are at a loss at this gruesome reward to a frontline worker in Covid duty. IMA demands immediate arrest of all the culprits and booking them under all stringent laws of the land," said IMA state president, Dr Satyajit Borah, and honorary secretary, Dr Sikha Sarma, in a statement.



True Copy

Workplace Violence Against Doctors in India: A Traditional Review

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Abstract

Workplace violence against doctors is not new, but in recent times, it has grown up in epidemic proportions. Doctors are more worried about their safety and life in the workplace. Meager government spending on healthcare associated with the poor socioeconomic status of the patient and the ever-rising cost of treatment had worsened the situation in present times. The article aims to address this critical issue and try to find possible ways to prevent it.

Categories: Family/General Practice, Epidemiology/Public Health

Keywords: workplace violence, doctors, india

Introduction And Background

According to the WHO framework Guidelines (2002), "Workplace violence is defined as the situations where staffs are ill-treated, intimidated or attacked in conditions linked to their workplace, including commuting to and from the workplace, involving an explicit or implicit challenge to their safety, well-being or health" [1]. Compared to all other workers, workplace violence seen in healthcare workers is four times higher and hence requires a longer time away from work [2]. It can be physical violence or psychological violence or a combination of both. It can be in any form like assault, abuse, bullying, mobbing, harassment either sexual or racial or psychological, threat, etc. [1].

Workplace violence against doctors is a global phenomenon. It has neither any region nor religion. It is prevalent not only in India, Pakistan, Bangladesh but also in developed countries like the USA, UK, and China. It is spread across the continents from Asia to Australia, Europe to America to Africa. Data shows that in the UK, one-third of healthcare workers had faced violence at the workplace [3]. In India, almost 75% of the doctors had dealt with one or the other form of violence during their practice [4]. Nearly 50% of violence were reported in intensive care units (ICUs), and in 70% of the cases, the patient relatives were actively involved [4]. Israel, Bangladesh, and Pakistan had also reported similar incidents [5-8]. The flawed healthcare system had led to a deteriorating relationship between the patient & doctor in China as well [9]. The Chinese Medical Doctor Association had reported more than 105 violent incidents between 2009 and 2015, where doctors were badly injured [10]. More than 100 healthcare workers died due to violence in the USA, between 1980 and 1990 [11]. As per the Indian Medical Association, over 80% of doctors are stressed out in their profession and nearly 56% don't sleep comfortably for 7 hours a day (Figure 1).

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A fear that's palpable

A recent survey by IMA reports that over 80% of doctors in India are stressed out in their profession

<p>56 per cent of doctors do not get a comfortable 7-hour sleep most days of the week</p> <p>13.7 per cent fear criminal prosecution most days of the week</p>	<p>82.7 per cent of doctors in India feel stressed out in their profession</p> <hr/> <p>46.3 per cent fear violence is the main cause of stress in many doctors</p> <hr/> <p>24.2 per cent doctors fear being sued</p> <hr/> <p>62.8 per cent of the doctors surveyed are unable to see their patients without any fear of violence</p> <hr/> <p>57.7 per cent have thought of hiring security in their premises</p>
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FIGURE 1: Violence and stress among Indian Doctors (Indian Medical Association)

(Retrieved from <https://www.thehindu.com/sci-tech/health/majority-of-doctors-in-india-fear-violence-says-ima-survey/article19198919.ece>.)

The same Indian Medical Association report states that 46% feel violence is the main cause of stress (Figure 2).

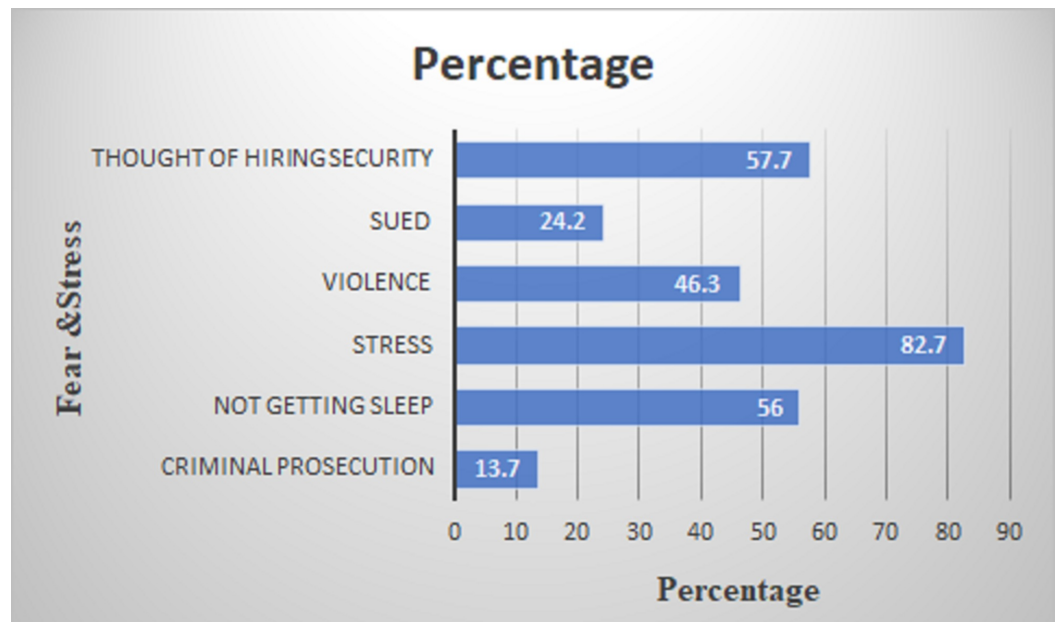


FIGURE 2: Fear and stress factors among Indian doctors

Timeline of major recent incidents in India

31 October 2019: Two residents of Banaras Hindu University, were beaten by patient attendants and goons in the parking space who escaped after the assault on motorbikes in Varanasi [12].

14 June 2019: A doctor was tied to a tree, robbed of his money and belongings; his wife and daughter were gang-raped in the Gaya district of Bihar [13].

11 June 2019: A junior resident doctor at Nil Ratan Sircar Medical College Hospital was hurled a brick to the head by the relatives of a 75-year-old patient. He suffered from a skull fracture and needed ICU admission [14].

5 June 2019: A Kolkata doctor was manhandled by the mob after the death of a six years old child in the Garden Reach area [15].

21 May 2019: The drunk attendants of a patient assaulted the Nizam's Institute of Medical Sciences (NIMS) doctor, Telangana [16].

12 May 2019: The medical officer in Dikom tea garden suffers from fractured ribs and broken bones after being assaulted by a mob in Assam [17].

27 February 2019: A junior doctor in the pediatric department of Gandhi Hospital, Hyderabad was assaulted by the grandmother of a 2-month-old baby who succumbed during treatment [18].

1 January 2019: A senior pediatrician was brutally assaulted by the patient's family at his clinic in Himayatnagar Hyderabad, Telangana [19].

9 February 2019: An on-duty ophthalmologist at the Central Hospital North Eastern Coalfields (NEC) Coal India LTD, Digboi, Assam was assaulted by some miscreants [20].

23 December 2018: A doctor on duty in the ICU of Kolkata Nursing Home was harassed and physically assaulted by the relatives of a patient complaining of chest pain [21].

2 December 2018: A doctor was assaulted by the villagers at the District Headquarter Hospital, Bhadrak, Odisha after the refusal of Mahaprayan Vehicle [22].

25 November 2018: Two nursing staff were physically assaulted by the patient attendants on night duty at the Patna Medical College and Hospital (PMCH) [23].

November 2018: A trainee doctor at the Chengelpettu Medical College, Tamil Nadu was assaulted by inebriated patient attendants [24].

15 October 2018: The relatives of a patient assaulted a reserved category doctor demanding the service of an upper-class doctor at Jabalpur, Madhya Pradesh [25].

30 August 2018: A police officer, who underwent wrist surgery, slapped the Junior doctor without provocation at the Calcutta Medical Research Institute (CMRI) hospital, Ekbalpore, West Bengal [26].

19 May 2018: A patient's relative beat up two resident doctors of JJ Hospital, Mumbai [27].

15 March 2017: An orthopedician at the Dhule government Hospital, Maharashtra, who was brutally assaulted by a patient's kin develops blurring of vision in one eye [28].

August 2016: The relatives of an alcoholic deceased patient brutally thrashed two medical

residents working at the Sassoon Medical College [29].

Review

Causes of violence

In India, more than 80% of doctors are stressed out due to various reasons like violence against them, harassment by police as well as politicians, long duration of the study, lack of personal or social life, etc as illustrated in Figure 3.



FIGURE 3: Factors stressing Indian doctors

The setting of violence against healthcare workers in India is different from that in the West. In India, violence perpetrators are mainly patient relatives, unknown sympathizers, criminal offenders, and even politicians [30]. In India, hardly 33% of the healthcare expenditure is borne by the government, the rest by the patients themselves. Low insurance penetration is another factor [31-32]. Unexpected healthcare expenses often push families into a trap of debt and financial instability. Here, within the background of smoldering anxiety of financial implications, verbal abuses easily escalate to violence. However, in the western world, the majority of the incidents occur during the night, in intensive care units and psychiatric and pediatric wards. Financial anxiety is not a causal factor in these countries as the healthcare expenditure is borne by the government [33]. The main offenders are the patients under the influence of drugs, alcohol, or psychiatric patients or their close relatives [34-35].

The causes of violence can be broadly categorized as poor quality healthcare in the majority of govt sector, the negative image of doctors and the role played by media, poor socioeconomic status of the patient and the ever-rising cost of the treatment, poor communication, vulnerability and susceptibility of hospitals, low awareness and knowledge about health-related issues, lax security or inadequate security arrangement, mob mentality, and instant justice.

A study by Verma et al. showed that young doctors are more prone and female doctors face more violence [36]. The highest rates of violence were reported in the Obstetrics and Gynaecology department, followed by the Department of Internal Medicine and Surgery. The same study also mentioned that the most common causes of violence are longer waiting periods, delay in attending the patient, and admission denial.

Most commonly, workplace violence against doctors is seen in the Casualty or Emergency department followed by other departments. Almost all doctors had reported verbal violence in the emergency or casualty department. Invariably the resident doctors are the first target of the irate mob. Male doctors face workplace violence more often than females.

Violence against doctors can be of any form like verbal abuse, physical violence, mob lynching harassment, etc. as can be seen in Figure 4. Verbal violence was the foremost common sort of violence.



FIGURE 4: Most common types of violence against Indian doctors

Violence against doctors had invariably resulted in a strike in the hospital over the years as cited in Figure 5.

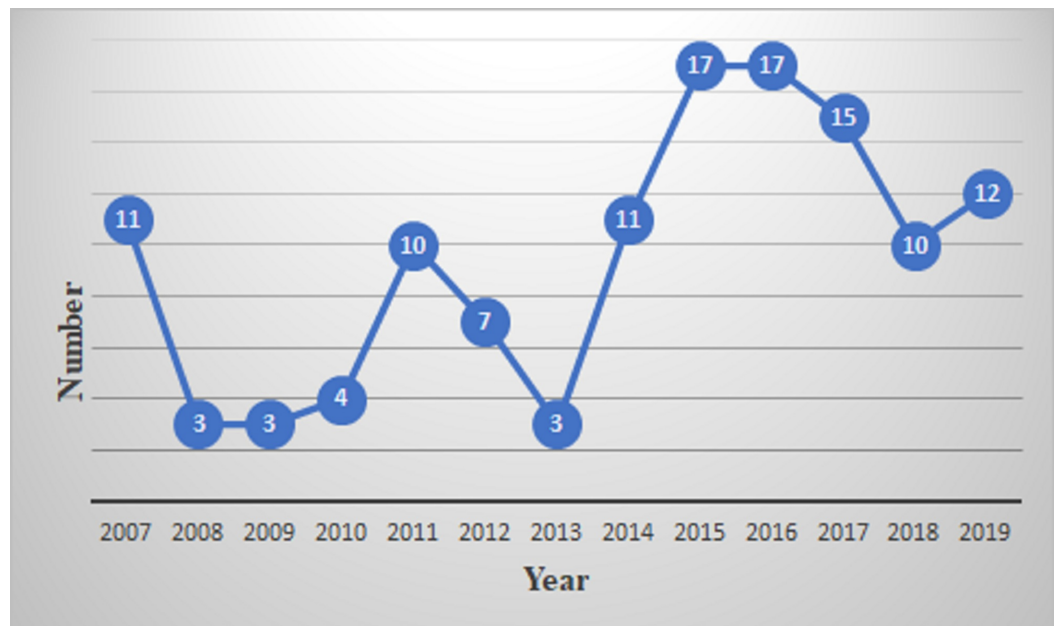


FIGURE 5: Violence against doctors leading to the number of strikes in hospitals reported in India from January 2007 to November 2019

Warning signs of violence

The STAMP (Staring, Tone, Anxiety, Mumbling, Pacing) approach alerts the physician by looking for early warning signs of violence. The STAMP approach consists of the following [37]:

Staring is a prospective sign of violence. Staring was to threaten them into a quicker response.

The tone and volume of voice are connected with violent episodes. Most cases involve not only raised voices and yelling but also sarcasm and caustic replies.

Anxiety in coming to the emergency department makes patients stressed out. Before it reaches dangerous levels, ideally the doctor intervenes, but sometimes, it escalates to violence due to patient anxiety.

Mumbling is an indication of violence as it reflects frustration. Pacing by relatives is seen as a symbol of agitation.

Prevention of violence against doctors

With the rise in mob violence incidents, doctors are also becoming cautious and reluctant to take up serious and grave cases, which in turn compromises healthcare which defeats the purpose of the healthcare delivery system. Unless we make the hospital environment free from fear and violence, the doctors won't be able to work to their maximum potential, and hence, stopping the violence against doctors is of paramount importance (Figure 6).



FIGURE 6: Stop violence against doctors

(Retrieved from <https://medicaldialogues.in/how-to-reduce-violence-against-doctors>)

Several steps can be taken in this direction. They are as follows:

Government Policies and Responsibilities

Change in government policies like increased government spending on healthcare, improving the infrastructure of the hospitals, stricter implementation of rules, laws, and punishment for violence under the Prevention of Violence against Doctors and Hospitals according to appropriate Acts and relevant sections of the Indian Penal Code (IPC), violence against health-care personnel and hospitals should be made a nonbailable offense and damages should be recovered from the persons responsible for the violence. The government should take responsibility for the safety of healthcare workers.

Steps Doctor Should Take

The doctors should take a few precautions while taking valid and informed consent. Audio-visual consent is preferred. Proper documentation has to be done. The next important thing is communication which should be done preferably in the patient's native language. Improving communication skills is another aspect of it. They shouldn't try to overdo or overreact and remain calm and composed.

Steps Institution Should Take

The standard operating procedure should be made and followed strictly. Code Purple should be declared and all measures should be taken in case of violence. Security staff to respond and assist immediately. All staff (except Operation Theatre & ICU) should form a human chain. All staff should remain calm & practice restraint. Closed-circuit television (CCTV) monitoring in sensitive areas is a must and should report to the Police immediately

Steps to be Taken by The Patient

Be aware of the health situation. Doctors practice medicine they can't do magic and certainly, not everyone can be revived. Doctors cannot be held responsible for every death occurring in the hospital on the ground of negligence. Cost increases with the type of treatment & its advancement. If not satisfied with a doctor can speak to the concerned authority and take an appropriate decision to continue treatment or not.

Steps to be Taken by Media

Must put forward the unbiased news. It shouldn't sensitize the news. It should highlight the doctor's predicament and the causes for the rise in violence against them.

Role of Medical Schools

The medical school can play an important role in creating awareness about workplace violence against doctors. Along with the medical subjects they should also teach about patient-doctor relations, communication with the patient in an effective way, empathy towards the patients and their relatives. The school should also teach them how to handle tactfully when the patients or their relatives behave aggressively and the situation turns chaotic and violent. They should teach them how to remain calm and responsible during those times without compromising the quality of patient care as well as safety.

The above steps can prevent workplace violence against doctors but the most important thing among them is communication by the doctor and the hospital. Proper communication can allay the situation or defuse the crisis. A senior doctor or someone from the management (preferably a senior one) should be able to communicate the condition and seriousness of the injury/disease of the patient to the relatives or attenders. A calm composed doctor with good communication skills can avert the situation most of the time. Along with that, the hospital security staff has to take steps to diffuse the mob and prevent violence against doctors and these hospitals. Police should be informed and kept vigilant if there is any suspicion of potential mob violence.

On the other way, the government should make stringent laws for violence against doctors in the workplace and punish the culprits. The government should improve the infrastructure of the hospitals and spend at least 5% GDP on healthcare which is neglected a lot. The media should avoid sensationalizing the news and put forward the unbiased news. Last but not the least patient education and creating awareness is a very important step towards preventing workplace violence against doctors.

Conclusions

Unless there is an entire overhaul of the prevailing healthcare system, it is a herculean task to curb violence against doctors. The medical curriculum should include soft skills and communication skills required to empathize, remain calm, and twiddling my thumbs regardless of repeated prodding by the anxious patients. Along with this increased communication between the doctors and patients, filling crucial gaps in communication between doctors, patients, and relatives will help in mitigating the violence in a long way.

Additional Information

Disclosures

Conflicts of interest: In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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**IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION
I.A NO. _____ OF 2022**

IN

WRIT PETITION (CIVIL) NO. _____ OF 2022

IN THE MATTER OF:

Dr.Suneet Kumar Upadhyaya & Ors.

Petitioners

Versus

Union of India &Ors.

Respondents

**APPLICATION FOR EXEMPTION FROM FILING OFFICIAL
TRANSLATIONS**

To

The Hon'ble Chief Justice of India and his Companion Justices of The Hon'ble Supreme Court of India

The Humble Application of The Petitioner Above Named

MOST RESPECTFULLY SHOWETH:-

1. The Petitioner is filing this Writ Petition in public interest under Article 32 of the Constitution of India to highlight the plight of registered medical practitioners and healthcare service providers, who are facing hostile action at the hands of the public and seeking issuance of guidelines that police officers should be sensitized against indiscriminate registration of criminal complaints against all healthcare service providers. Further, the Petitioner is also praying for issuance of appropriate directions pertaining to the cases of violence against healthcare service providers including directions to the Respondents for providing safety to healthcare service providers at the workplace along with directions to compensate healthcare service providers and their families in the event of violence and frivolous prosecutions.
2. The facts of the case are set out in the accompanying Writ Petition and are not being reiterated for the sake of brevity.

3. Along with the Writ Petition the Petitioners have filed some annexures i.e. Annexure P-1 and P-2 which are originally in the vernacular but are important for the adjudication of this Special Leave Petition. Due to the urgency involved the Petitioners have not got the official translation done which would take time, but has got a true translation done to the best of their knowledge.
4. Hence it is prayed that this Hon'ble Court may exempt the Petitioner from filing the official translations of the said documents.
5. This Application is filed bonafide and in the interests of justice.


PRAYER

It is most respectfully prayed that this Hon'ble Court may be pleased to:

- A) Exempt the Petitioners from filing official translation of Annexure P-1 and P-2 filed along with this Writ Petition;
- B) Pass any other or further orders as may be deemed fit and proper in the circumstances of the case.

AND FOR THIS ACT OF KINDNESS THE PETITIONER AS IN DUTY BOUND SHALL EVER PRAY.

FILED ON :20.04.2022
NEW DELHI

FILED BY

POOJA BHAT
Advocate for the Petitioners

**IN THE SUPREME COURT OF INDIA
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Versus

Union of India &Ors.

Respondents

APPLICATION FOR SEEKING EXEMPTION FROM FILING DULY \NOTARISED

AFFIDAVITS

TO

THE HON'BLE CHIEF JUSTIC OF INDIA
AND HIS HON'BLE COMPANION JUSTICES OF INDIA
THE HON'BLE SUPREME COURT OF INDIA

THE HUMBLE APPLICATION OF
THE APPLICANT ABOVENAMED

MOST RESPECTFULLY SHOWETH:

1. The Petitioner is filing this Writ Petition in public interest under Article 32 of the Constitution of India to highlight the plight of registered medical practitioners and healthcare service providers, who are facing hostile action at the hands of the public and seeking issuance of guidelines that police officers should be sensitized against indiscriminate registration of criminal complaints against all healthcare service providers. Further, the Petitioner is also praying for issuance of appropriate directions pertaining to the cases of violence against healthcare service providers including directions to the Respondents for providing safety to healthcare service providers at the workplace along with directions to compensate healthcare service providers and their families in the event of violence and frivolous prosecutions.

2. The facts of the case are set out in the accompanying Writ Petition, and are not being reiterated for the sake of brevity. However by way of brief background the necessary facts as relevant to this application are as below.
3. That the accompanying Writ Petition has been filed by the Petitioner along with duly affirmed and signed affidavits. It is most respectfully submitted that, by way of present application the Petitioner is seeking exemption from filing the notarised affidavits along with the Writ Petition, in the view of the prevailing circumstances, due to COVID-19. It is submitted that the petitioner is living in Rajasthan, and is down with fever, therefore, it is not possible for him to go to notary and get the affidavit attested . It is respectfully submitted that due to paucity of time and urgent nature of the Writ Petition the Petitioner is constrained to file the present Application. The Applicant undertakes to file the physical copies of the duly notarized affidavits, as and when directed by this Hon'ble Court.
4. The present Application has been filed in the interest of justice. The Petitioner/Applicant has good case on merits and would suffer grave harm if the present application is not allowed.


PRAYER

It is therefore, most humbly prayed that this Hon'ble Court may be pleased to:

- a) Exempt the Applicant from filing duly notarised affidavits along with the Writ Petition;
- b) Pass such other and/or further order (s) as this Hon'ble Court may deem just and proper in the facts and circumstances of the case.

AND FOR THIS ACT OF KINDNESS, THE APPLICANT AS IN DUTY BOUND SHALL EVER PRAY.

New Delhi
Date :20.04.20225

FILED BY

(POOJA DHAR)
Advocate for the Petitioners

IN THE SUPREME COURT OF INDIA

Civil/ CRL / Appellate / Original Jurisdiction

Special Leave Petition (Civil/Crl.) No.

of 20

Civil/Criminal/Appeal/Writ Petition No.

of 20 *22*

T.P Civil/Criminal/ No.

of 20

IN THE MATTER OF :

*Dr. Suneet Kumar Upadhyay*PETITIONER (S)
APPELLANT (S)**VERSUS***Union of India & Ors*

RESPONDENT (S)

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8	<i>filing Duty Waiver Affidavit</i>		
9	<i>Vakalatnama</i>		
10			<i>1230/-</i>
			Total Court fee.....

Filed by:

All copies are correct

Filed on *18.04.2022*..2022

(CLERK)

VELMURGAN

I.C. NO.4570

Mob.9650833678

KAMRAJ

MOB. No.9711224682

I.C. NO.5220

(Ms. Pooja Dhar)

COMPUTER CODE:2048

Email id. officeofpoojadhar@gmail.com

Advocate for the Petitioner /Appellant /Respondent

C-203,LGF, Defence Colony

New Delhi-110024

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**IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION
WRIT PETITION (CIVIL) NO. _____ OF 2022
[UNDER ARTICLE 32 OF THE CONSTITUTION OF INDIA]
PUBLIC INTEREST LITIGATION**

IN THE MATTER OF:

Dr. Suneet Kumar Upadhyaya & Ors

.....Petitioner

Versus

Union of India & Ors.

.....Respondent

VAKALATNAMA

I/We... Dr. Suneet Kumar Upadhyaya..Petitioner(s)/Respondent(s)/Appellant(s) in the above Petition/Appeal/Reference/Suit do hereby appoint and retain **POOJA DHAR**, Advocate on Record of the Supreme Court of India, to act and appear for me/us in the above Petition/Appeal/Suit/Reference and on my/ our behalf to conduct and prosecute (or defend) the same and all proceedings that may be taken in respect of any application connected with the same or any decree or order passed therein, including proceedings in taxation and application for Review, to file and obtain return of documents, and to deposit and receive money on my/our behalf in the said Petition/Appeal/Reference/suit and in application for Review, and to represent me/us and to take all necessary steps on my/our behalf in the above matter. I/We agree to ratify all acts done by the aforesaid Advocate in pursuance of this authority.

Dated this the.....**14th**.....day of**April**.....2022

Accepted: Identified & Certified

POOJA DHAR
Advocate, Supreme Court
C.C-2048
Email Id. officeofpoojadar@gmail.com

Dr. Suneet Kumar Upadhyaya P-1

Dr. Kaushal Kant Mishra P-2

Petitioner(s)/Appellant(s)/Respondent(s)

MEMO OF APPEARANCE

To
The Registrar,
Supreme Court of India,
New Delhi.
Sir

Please enter my appearance on behalf of the Petitioner(s)/Appellant(s)/Respondent(s) in the above matter.



Yours Faithfully,

Dated....**18.04**.....2022

POOJA DHAR
Advocate for the Petitioner(s)
Appellant(s)/Respondent(s)

The Address for Service of the said Advocate is
Office:
C-203, LGF, Defence Colony, New Delhi-110024
Tel no. 011-45694200, Mobile No. 9810488621

IN THE SUPREME COURT OF INDIA
CIVIL / CRIMINAL / APPELLATE / ORIGINAL JURISDICTION

S.L.P./C.P.W.P./S.D./A.P.P./A.L. (Civil/Cr.) No.


of 2020


Dr. Suneet Kumar Upadhyay & Ors.**Appellant (s)****VERSUS****Union of India & Ors****Respondent (s)****VAKALATNAMA**

I/WE **Dr. Vishwa Priya Sharma** Petitioner(s)/Respondent(s)
/Appellant(s) in the above Petition/Appeal/Reference/Suit do hereby appoint and retain **POOJA DHAR**, Advocate on Record of the Supreme Court of India, to act and appear for me/us in the above Petition/Appeal/Suit/Reference and on my/ our behalf to conduct and prosecute (or defend) the same and all proceedings that may be taken in respect of any application connected with the same or any decree or order passed therein, including proceedings in taxation and application for Review, to file and obtain return of documents; and to deposit and receive money on my/our behalf in the said Petition/Appeal/Reference/suit and in application for Review, and to represent me/us and to take all necessary steps on my/our behalf in the above matter. I/We agree to ratify all acts done by the aforesaid Advocate in pursuance of this authority.

Dated this the **19th** day of **April** 20**20**

Accepted: Identified & Certified


POOJA DHAR
Advocate, Supreme Court
C.C-2048
Email Id. poojadhar@gmail.com


Dr Vishwa Priya Sharma - P-3
Petitioner(s)/Appellant(s)/Respondent(s)

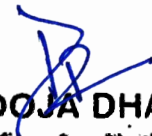
MEMO OF APPEARANCE

To
The Registrar,
Supreme Court of India,
New Delhi.
Sir

Please enter my appearance on behalf of the Petitioner(s)/Appellant(s)/Respondent(s) in the above matter.

Dated **20.04.2022**
.....2018

Yours Faithfully



POOJA DHAR
Advocate for the Petitioner(s)
Appellant(s)/Respondent(s)

The Address for Service of the said Advocate is
Office:
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P-1



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भारत सरकार
Government of India

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

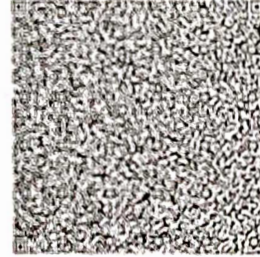
नामांकन क्रम / Enrollment No. : 0013/12011/29434

To Suneet Kumar Upadhyaya
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भारत सरकार

Government of India



Issue Date: 03/02/2012



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भारतीय विशिष्ट पहचान प्राधिकरण

भारत सरकार
Unique Identification Authority of India
Government of India

नामांकन क्रम / Enrollment No.: 1171/23550/48872

To
कौशल कान्त मिश्रा
Kaushal Kant Mishra
S/O: Krishna Kant Mishra
Bhuwa Kalan
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Vishwa Priya Sharma
पत्नी / Wife : गीता भट्ट
जन्म वर्ष / Year of Birth : 1954
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आधार

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