CHAPTER ELEVEN

MEDICAL NEGLIGENCE, CONSUMER PROTECTION, AND REPRODUCTIVE HEALTH

The question of whether medical services are covered under the Consumer Protection Act, 1986, was answered by the Supreme Court in the landmark case, ***Indian Medical Association v. V. P. Shantha***.[1] The Court held that the services provided by medical practitioners or at a hospital are covered under the Consumer Protection Act, 1986, except when such service is provided free of charge to every patient or when provided under a contract of personal service. Consequently, consumer disputes redressal agencies may be approached for seeking relief in case of deficiency in reproductive health services and medical negligence.

The Supreme Court has approved the test laid down in ***Bolam v. Friern Hospital Management Committee***[2] (Bolam Test) for determining a medical practitioner's liability for negligence.[3] Thus, the standard against which the practitioner's conduct is judged is of an "*ordinary competent person exercising ordinary skill in that profession.*"[4]

In ***Achutrao Haribhau Khodwa v. State of Maharashtra***,[5] the Supreme Court held a doctor guilty of negligence for failure to act with reasonable skill and care as he had left a mop inside the body of a woman during the sterilization operation that caused her death. Likewise, the Delhi High Court in ***R. R. Rana v. State***,[6] refused to interfere with the charge framed under Section 338 of the Indian Penal Code, 1860, against the doctor, noting that the nature of injuries suffered by the woman during the medical termination of her pregnancy could not have been caused by a professional acting with ordinary prudence.

In this section, we discuss the following issues relating to negligence in provision of reproductive health services:

- Sterilization, Medical Negligence, and Liability of the State.[7]
    - Burden of Proving Negligence
    - Liability of the State for Medical Negligence
    - Liability of the State for the Upbringing of an Unintended Child
    - Liability of the State for not Providing Adequate Health-Care Facilities
- Removal of Uterus/Ovaries of a Woman Without Her Consent

Sterilization, Medical Negligence, and Liability of the State

The Supreme Court in ***State of Haryana v. Santra***,[8] held the doctor of a government hospital liable for "negligence *per se*" as he had conducted an "incomplete" sterilization procedure by leaving one of the fallopian tubes unoperated. Noting that the woman had sought complete sterilization, the Court awarded damages on account of childbirth consequent to sterilization procedure.

The Madhya Pradesh High Court in ***State of M.P. v. Smt Sundari Bai***,[9] held that a doctor would not be liable for negligence for adopting a particular method of sterilization, where there exists more than one "perfectly proper standard." Distinguishing ***Santra*** as a case of incomplete sterilization and negligence *per se*, the Court held that the doctor had performed a well-recognized sterilization procedure with a reasonable degree of care and skill and added that an error of judgment cannot be equated with negligence. In contrast, the Himachal Pradesh High Court in ***State of H.P. v. Madhu Bala***,[10] relied on ***Santra*** to hold that the presumption of negligence *per se* stood unrebutted as the doctor had not adopted the "latest in vogue" method of sterilization.

A three-judge bench of the Supreme Court in ***State of Punjab v. Shiv Ram***,[11] laid down the standard position for awarding compensation in cases of failed sterilizations. The Court stated that ***Santra*** did not lay down a universal standard and proceeded on the fact of proven negligence. Noting that none of the methods of sterilization is error-free, the Court held that only where the doctor is negligent (as per the Bolam Test) or gives an unequivocal guarantee that sterilization will not lead to any pregnancy, can compensation be awarded.[12] The Supreme Court in ***Martin F. D'Souza v. Mohd. Ishfaq***,[13] noted that the approach in ***Santra*** stands overruled with the decisions in ***Shiv Ram*** and ***Raj Rani***.[14] Various High Courts have followed ***Shiv Ram*** to deny compensation in the absence of proof of negligence.[15] In ***State of H.P. v. Sushma Sharma***,[16] the Himachal

Pradesh High Court held the doctor liable for negligence for breach of duty as she had assured the woman undergoing sterilization that she would not bear any pregnancy in the future and also failed to apprise her of postoperative precautions. The court also noted the educational status of the woman in terms of her being able to understand the contents of the consent form, and held it to be a relevant factor in determining whether effective informed consent was obtained.[17]

BURDEN OF PROVING NEGLIGENCE

In ***Sumathi v. Dr. Suganthi***,[18] the Madras High Court held that the burden of proving absence of negligence lies heavily on the doctor, stating that the lower court had erred in shifting the burden to prove negligence on the woman, who belonged to a weaker section of society.

LIABILITY OF THE STATE FOR MEDICAL NEGLIGENCE

The Supreme Court in ***Achutrao Haribhau Khodwa***,[19] while holding a government doctor liable for negligence, also imposed vicarious liability on the state. It rejected the state's claim of sovereign immunity, holding that although maintaining a hospital is a "welfare activity" of the government, it is not an "exclusive" function or activity which amounts to exercise of sovereign power.

An expansive approach has been adopted by the Kerala High Court in ***State of Kerala v. Santa***,[20] where it has held that aside from the vicarious liability, the state would be liable on account of promissory estoppel and will have a "constitutional responsibility" as inferred from the fundamental duties, directive principles of state policy, and fundamental rights to make good the damage suffered by a citizen who undergoes sterilization based on the state's assurance that it is an error-free method of birth control and who suffers upon its failure.

LIABILITY OF THE STATE FOR UPBRINGING OF AN UNINTENDED CHILD ("WRONGFUL BIRTH")

Highlighting the importance of family planning programmes in a developing country such as India with increasing population, the Supreme Court in ***Santra*** held that the state would be responsible to provide damages for bringing up the "unwanted child" born as a result of failed sterilization caused due to negligence of the doctor. Considering the poor economic background of the woman who underwent sterilization, the Court allowed her to claim damages for the upbringing of her child up to age of puberty.

The approach in ***Santra*** no longer holds good with the Supreme Court's decision in ***Shiv Ram***, where it has stated that a cause of action for compensation in case of failed sterilization arises only on negligence and not childbirth. The Court added that if a woman opts to bear the child, then such child ceases to be an unintended child and compensation cannot be claimed for the child's maintenance and upbringing. The Court, however, advised the government to establish a welfare fund or insurance scheme to provide relief in case of failed sterilization, particularly to persons belonging to lower strata of the society.

The Delhi High Court in ***Nirmala Devi v. Union of India***,[21] held that there was no principle to award compensation for bringing up a mentally challenged child born as a result of failed sterilization, since there was no finding of negligence in this case.

COMPENSATION FOR FAILURE OF STATE TO PROVIDE ADEQUATE HEALTH-CARE FACILITIES

In ***S. Mary v. Union of India***,[22] the Madras High Court awarded compensation for loss of child and removal of uterus to a woman whose caesarean operation was delayed because of non-availability of hospital beds. The Court held that the woman's right to life and health under Article 21 of the Indian Constitution had been jeopardized.[23]

Removal of Uterus or Ovaries Without Consent

In cases where the uterus and/or ovaries of a woman are removed without her consent in the course of a diagnostic or surgical procedure, courts have not held the doctors guilty of negligence if such removal was necessary for saving the woman's life or preserving her health. The principle was enunciated by the Supreme Court in ***Samira Kohli v. Dr. Prabha Manchanda***.[24] The Court held that the following constitute real and valid consent: (i) the patient has the capacity to consent; (ii) the patient consents voluntarily; and (iii) the patient has the adequate level of information about the nature of the medical procedure. The adequacy of such information would be assessed as per the Bolam Test. Further, it held

that consent for a particular treatment will not be valid for another treatment except in case of an emergency when it is unreasonable to delay until consent is obtained. While considering the quantum of compensation for negligence,[25] the Court considered the woman's age and health, repercussions of hysterectomy, and good faith on part of the doctor as mitigating factors.

Related Human Rights Standards and Jurisprudence

Below is a selection of international human rights laws and standards concerning state parties' obligation to protect individuals from rights violations that may be perpetrated by private third parties, including through negligent medical care. Under human rights law, governments are obligated to prohibit third parties from violating sexual and reproductive health and rights, punish violators, and ensure that victims have access to adequate judicial and other remedies.

The Government of India has committed itself to comply with the obligations outlined in various international human rights treaties that protect sexual and reproductive health and rights. These include the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW), and the International Covenant on Civil and Political Rights (ICCPR).[26] Under international law, all government organs and authorities, including the judiciary, are obligated to uphold the laws and standards outlined in these treaties.[27] The Supreme Court has held that in light of the obligation to "foster respect for international law" in Article 51 (c) of the Indian Constitution "[a]ny International Convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into [fundamental rights] to enlarge the meaning and content thereof, to promote the object of the constitutional guarantee."[28]

INTERNATIONAL TREATY STANDARDS

TREATIES

- **ICCPR, Articles 2(1), 3, 5, 6, 17** (guaranteeing the equal rights of men and women and prohibiting discrimination on the basis of sex; protecting the rights to life, including freedom from arbitrary deprivations of life, and privacy).
- **ICESCR, Articles 10, 12, 15** (protecting the rights to the highest attainable standard of physical and mental health and to "special protection" for women before and after childbirth; and to guarantee the right to "enjoy the benefits of scientific progress and its applications," including by ensuring "the development and the diffusion of science").
- **CEDAW, Articles 4(2), 10(h), 12** (outlining women's equal right to health, including by accommodating women's specific reproductive health needs and ensuring access to reproductive health information).

SELECTED GENERAL COMMENTS

- **Committee for Economic Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12),*** U.N. Doc. E/C.12/2000/4 (2000), paras. 12, 18–23, 33–37, 50–52, 59–62 (the right to health entitles individuals to available, accessible, acceptable, and good-quality health-care information, facilities, goods and services on a basis of non-discrimination; states' obligation to respect, protect, and promote the right to health includes the duty to ensure that third parties do not undermine the right to health and that where violations do occur, effective judicial remedy is available).
- **Committee for Economic Social and Cultural Rights, *General Comment No. 22 (2016) on the right to sexual and reproductive health,*** U.N. Doc. E/C.12/GC/22 (2016), paras. 42–49, 54–55, 59–63 (states must take effective steps to monitor, regulate, and otherwise prevent third parties—including private health-care providers, health-insurance companies, educational institutions, and detention centres—from undermining the enjoyment of the right to sexual and reproductive health, including by ensuring that in practice, health-related information, goods, and services meet the standards of available, accessible, acceptable, and quality care).

- **CEDAW Committee,** ***General Recommendation No. 24: Article 12 of the Convention (women and health),*** U.N. Doc. A/54/38/Rev.1, chap. I (1999), paras. 11–15, 17, 20–22, 31(d)–(e) (outlining the state responsibility to respect, protect, and fulfill women's equal right to health, including by ensuring women's access to care on the basis of fully informed consent, without discrimination or third-party consent requirements; requiring that all public and private health-care providers implement appropriate health-care standards; and imposing sanctions on public and private care providers who violate the right to health particularly in the context of gender-based violence).
- **CEDAW Committee,** ***General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19,*** U.N. Doc. CEDAW/C/GC/35 (2017), paras. 24–26 (outlining state responsibility to adopt and implement effective measures to prevent and punish gender-based violence against women committed by nonstate actors, including legislative, executive, and judicial measures that ensure reparations in case of rights violations by private parties).
- **Committee on the Rights of the Child,** ***General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (Art. 24),*** U.N. Doc. CRC/C/GC/15 (2013), paras. 75–85 (outlining the state duty to impose and enforce specific obligations of nonstate actors to support the health of children and mothers, including by requiring health-related private sector entities to comply with due diligence and other human rights standards).

INQUIRIES AND INDIVIDUAL COMPLAINTS

- **CEDAW Committee,** ***Summary of the inquiry concerning the Philippines under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women,*** U.N. Doc. CEDAW/C/OP.8/PHL/1 (2015), paras. 21–25, 45, 51 (f), 51 (h)–(k), 52(g) (establishing state duties to impose safeguards and oversight mechanisms on decentralized health-care providers at the local level; to ensure that local hospital procedures and practices facilitate reporting, investigating, and punishing discrimination and abuse; and to implement a system to ensure effective judicial protection and remedies for sexual and reproductive rights violations).

UNITED NATIONS HUMAN RIGHTS EXPERT REPORTS

- **Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (SR Health),** ***Report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,*** U.N. Doc. A/64/272 (2009), paras. 93–95, 101 (emphasizing the importance of implementing an effective legal framework and judicial and administrative mechanisms to ensure that both the state and third parties respect, protect, and fulfill patients' rights, in practice, to informed consent in medical care).
- **SR Health,** ***The right of everyone to the enjoyment of the highest attainable standard of physical and mental health (by Paul Hunt),*** U.N. Doc. A/60/348 (2005), paras. 8–17 (emphasizing the need for health professionals to receive human rights training; highlighting that patients seeking reproductive health services are at particularly high risk of human rights violations; and outlining that states must "not place health professionals in a position where they may be called on to use their skills to further violations of human rights" of their patients and must provide "accountability mechanisms to redress or prevent human rights violations in the context of clinical practice").
- **SR Health,** ***The right of everyone to the enjoyment of the highest attainable standard of physical and mental health,*** U.N. Doc. E/CN.4/2004/49 (2004), paras. 41–44, 48–49, 73, 85, 88 (giving a brief overview of the right to sexual and reproductive health care that is available, accessible, acceptable, and of good quality, as well as the state obligation to respect, protect and fulfill the right to health, including by ensuring the implementation of "effective, accessible and transparent mechanisms of accountability in relation to all duty-bearers").

SELECTED REGIONAL CASE LAW

EUROPEAN COURT OF HUMAN RIGHTS

- ***Konovalova v. Russia,* Application No. 37873/04 (2015)**, paras. 39–50 (holding that the laws had not provided adequate protection for the applicant's right to medical privacy, thereby compromising her right to choose, on the basis of informed consent, whether medical students would be able to participate in and "study" her childbirth; and that the domestic courts had not adequately examined her claims).
- ***A.K. v. Latvia,* Application No. 33011/08 (2014)**, paras. 84–94, 105 (in a case where the applicant had been negligently denied adequate and timely antenatal testing that would have allowed her to choose whether to terminate her pregnancy: holding that the domestic courts had failed to protect applicant's right to privacy and personal integrity by not properly examining her domestic legal claim, and awarding her 5,000 euros in damages plus costs and expenses).
- ***Csoma v. Romania,* Application No. 8759/05 (2013)**, paras. 41–43, 61–68 (in case of negligent sterilization without consent: finding a violation of the state's positive obligation to protect the petitioner's right to private life where the state had failed to put in place a system to hold the appropriate health-care professionals and institutions accountable, rendering it impossible for the victim to obtain adequate redress).
- ***Mehmet Şentürk and Bekir Şentürk v. Turkey,* Application No. 13423/09 (2013)**, paras. 79–109 (where medical staff failed to provide emergency care, despite a known critical condition, resulting in the death of a pregnant woman and her foetus: holding that both the substantive and procedural aspects of the woman's right to life had been violated by, respectively, the negligence of hospital authorities and the inadequacy of the pursuant criminal proceedings; ruling separately that an unborn foetus does not attract protections under the right to life).
- ***G.B. and R.B. v. the Republic of Moldova,* Application No. 16761/09 (2012)**, paras. 29–34 (holding that the state had failed to uphold the applicant's right to privacy and personal integrity under Article 8 when the domestic court, upon finding a negligent violation of the applicant's right to informed consent to sterilization, did not award adequate compensation for pain and suffering).

INTER-AMERICAN COURT OF HUMAN RIGHTS

- ***Gonzales Lluy et al. v. Ecuador,* Preliminary Objections, Merits, Reparations and Costs, Series C No. 298 (2015)** at § XXI—Reparations (in a case of negligent infection with HIV and subsequent discrimination based on HIV status: finding violations of the rights to life, humane treatment, and physical, mental, and moral integrity where the state failed to ensure adequate medical care from both public and private providers and to ensure an adequate remedy; ordering the state to provide restitution, rehabilitation, reparations, and guarantees of non-repetition).

RELEVANT EXCERPTS FROM SELECT CASE LAW

(Arranged chronologically)

IN THE SUPREME COURT OF INDIA

Indian Medical Association v. V.P. Shantha
(1995) 6 SCC 651
Kuldip Singh, S.C. Agrawal and B.L. Hansaria, JJ.

The issue before the Supreme Court was whether, and if so under what circumstances, the service rendered by a medical practitioner or at a hospital/nursing home can be construed as "service" under Section 2 (1)(o) of the Consumer Protection Act, 1986.

Agrawal, J.: "…

2. These appeals, special leave petitions and the writ petition raise a common question, viz., whether and, if so, in what circumstances, a medical practitioner can be regarded as rendering 'service' under Section 2(1)(*o*) of the Consumer Protection Act, 1986 (hereinafter referred to as 'the Act'). Connected with this question is the question whether the service rendered at a hospital/nursing home can be regarded as 'service' under Section 2(1)(*o*) of the Act. These questions have been considered by various High Courts as well as by the National Consumer Disputes Redressal Commission (hereinafter referred to as 'the National Commission').

…

11. …Since the Act gives protection to the consumer in respect of service rendered to him, the expression 'service' in the Act has to be construed keeping in view the definition of 'consumer' in the Act. It is, therefore, necessary to set out the definition of the expression 'consumer' contained in Section 2(1)(*d*) insofar as it relates to services and the definition of the expression 'service' contained in Section 2(1)(*o*) of the Act. The said provisions are as follows—

> "2. (1)(*d*) 'consumer' means any person who,—
>
> (*i*) [*Omitted*]
>
> (*ii*) hires or avails of *any services for a consideration which has been* paid or *promised* or partly paid and partly promised, or under any system of deferred payment and includes any *beneficiary of such services* other than the person who hires or avails of the service for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person.
>
> *Explanation.*— [*Omitted*]"
>
> (emphasis added)
>
> "2. (1)(*o*) 'service' means service of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information, *but does not include rendering of any service free of charge* or under a contract of personal service;"
>
> (emphasis added)

…

13. The definition of 'service' in Section 2(1)(*o*) of the Act can be split up into three parts — the main part, the inclusionary part and the exclusionary part. The main part is explanatory in nature and defines service to mean service of any description which is made available to the potential users. The inclusionary part expressly includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information. The exclusionary part excludes rendering of any service free of charge or under a contract of personal service.

14. The definition of 'service' as contained in Section 2(1)(*o*) of the Act has been construed by this Court in *Lucknow Development Authority v. M.K. Gupta* [(1994) 1 SCC 243]. After pointing out that the said definition is in three parts, the Court has observed: (SCC p. 255, para 4)

"The main clause itself is very wide. It applies to any service made available to potential users. The words 'any' and 'potential' are significant. Both are of wide amplitude […] The use of the word 'any' in the context it has been used in clause (*o*) indicates that it has been used in wider sense extending from one to all. The other word 'potential' is again very wide[…].In other words service which is not only extended to actual users but those who are capable of using it are covered in the definition. The clause is thus very wide and extends to any or all actual or potential users."

15. The contention that the entire objective of the Act is to protect the consumer against malpractices in business was rejected with the observations: (SCC p. 256, para 5)

> "The argument proceeded on complete misapprehension of the purpose of Act and even its explicit language. In fact the Act requires provider of service to be more objective and caretaking."
>
> Referring to the inclusive part of the definition it was said: (SCC p. 257, para 6)
>
> "The inclusive clause succeeded in widening its scope but not exhausting the services which could be covered in earlier part. So any service except when it is free of charge or under a constraint of personal service is included in it."

…

17. In the present case the inclusive part of the definition of 'service' is not applicable and we are required to deal with the questions falling for consideration in the light of the main part and the exclusionary part of the definition. The exclusionary part will require consideration only if it is found that in the matter of consultation, diagnosis and treatment, a medical practitioner or a hospital/nursing home renders a service falling within the main part of the definition contained in Section 2(1)(*o*) of the Act. We have, therefore, to determine whether medical practitioners and hospitals/nursing homes can be regarded as rendering a 'service' as contemplated in the main part of Section 2(1)(*o*). This determination has to be made in the light of the aforementioned observations in *Lucknow Development Authority* [(1994) 1 SCC 243]. We will first examine this question in relation to medical practitioners.

18. It has been contended that in law there is a distinction between a profession and an occupation and that while a person engaged in an occupation renders service which falls within the ambit of Section 2(1)(*o*), the service rendered by a person belonging to a profession does not fall within the ambit of the said provision and, therefore, medical practitioners who belong to the medical profession are not covered by the provisions of the Act. It has been urged that medical practitioners are governed by the provisions of the Indian Medical Council Act, 1956 and the Code of Medical Ethics made by the Medical Council of India, as approved by the Government of India under Section 3 of the Indian Medical Council Act, 1956 which regulates their conduct as members of the medical profession and provides for disciplinary action by the Medical Council of India and/or State Medical Councils against a person for professional misconduct.

…

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*, paras 1-04, 1-05 and 1-56).

…

26. We are…unable to subscribe to the view that merely because medical practitioners belong to the medical profession they are outside the purview of the provisions of the Act and the services rendered by medical practitioners are not covered by Section 2(1)(*o*) of the Act.

27. Shri Harish Salve, appearing for the Indian Medical Association, has urged that having regard to the expression "which is made available to potential users" contained in Section 2(1)(*o*) of the Act, medical practitioners are not contemplated by Parliament to be covered within the provisions of the Act. He has urged that the said expression

is indicative of the kind of service the law contemplates, namely, service of an institutional type which is really a commercial enterprise and open and available to all who seek to avail thereof. In this context, reliance has also been placed on the word 'hires' in sub-clause (*ii*) of the definition of 'consumer' contained in Section 2(1)(*d*) of the Act. We are unable to uphold this contention…By inserting the words "or avails of" after the word 'hires' in Section 2(1)(*d*)(*ii*) by the Amendment Act of 1993, Parliament has clearly indicated that the word 'hires' has been used in the same sense as "avails of"...The word 'user' in the expression "which is made available to potential users" in the definition of 'service' in Section 2(1)(*o*) has to be construed having regard to the definition of 'consumer' in Section 2(1)(*d*)(*ii*) and, if so construed, it means "availing of services". From the use of the words "potential users" it cannot, therefore, be inferred that the services rendered by medical practitioners are not contemplated by Parliament to be covered within the expression 'service' as contained in Section 2(1)(*o*).

…

29. The submission of Shri Salve is that under the said clause, the deficiency with regard to fault, imperfection, shortcoming or inadequacy in respect of a service has to be ascertained on the basis of certain norms relating to quality, nature and manner of performance and that medical services rendered by a medical practitioner cannot be judged on the basis of any fixed norms and, therefore, a medical practitioner cannot be said to have been covered by the expression 'service' as defined in Section 2(1)(*o*). We are unable to agree. While construing the scope of the provisions of the Act in the context of deficiency in service it would be relevant to take note of the provisions contained in Section 14 of the Act which indicate the reliefs that can be granted on a complaint filed under the Act. In respect of deficiency in service, the following reliefs can be granted:

> (*i*) return of the charges paid by the complainant. [clause (*c*)]
>
> (*ii*) payment of such amount as may be awarded as compensation to the consumer for any loss or injury suffered by the consumer due to the negligence of the opposite party. [clause (*d*)]
>
> (*iii*) removal of the defects or deficiencies in the services in question. [clause (*e*)]

30. Section 14(1)(*d*) would, therefore, indicate that the compensation to be awarded is for loss or injury suffered by the consumer due to the negligence of the opposite party. A determination about deficiency in service for the purpose of Section 2(1)(*g*) has, therefore, to be made by applying the same test as is applied in an action for damages for negligence. The standard of care which is required from medical practitioners as laid down by McNair, J. in his direction to the jury in *Bolam*v. *Friern Hospital Management Committee* [(1957) 1 WLR 582 : (1957) 2 All ER 118] , has been accepted by the House of Lords in a number of cases. (See: *Whitehouse*v. *Jordan* [(1981) 1 WLR 246 : (1981) 1 All ER 267] ; *Maynard v. West Midlands Regional Health Authority* [(1984) 1 WLR 634 : (1985) 1 All ER 635] ; *Sidaway v. Governors of Bethlem Royal Hospital* [1985 AC 871 : (1985) 1 All ER 643 : (1985) 2 WLR 480] .) In *Bolam* [(1957) 1 WLR 582 : (1957) 2 All ER 118] McNair, J. has said: (All ER p. 121)

> "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 special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."

31. In an action for negligence in tort against a surgeon this Court, in *Laxman Balkrishna Joshi v. Trimbak Bapu Godbole* [(1969) 1 SCR 206 : AIR 1969 SC 128] has held: (SCR p. 213)

> "The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the 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 give 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 require."

32. It is, therefore, not possible to hold that in view of the definition of 'deficiency' as contained in Section 2(1)(*g*), medical practitioners must be treated to be excluded from the ambit of the Act and the service rendered by them is not covered under Section 2(1)(*o*).

…

37. …We are, therefore, unable to hold that on the ground of composition of the Consumer Disputes Redressal Agencies or on the ground of the procedure which is followed by the said Agencies for determining the issues arising before them, the service rendered by the medical practitioners are not intended to be included in the expression 'service' as defined in Section 2(1)(*o*) of the Act.

38. Keeping in view the wide amplitude of the definition of 'service' in the main part of Section 2(1)(*o*) as construed by this Court in *Lucknow Development Authority* [(1994) 1 SCC 243] , we find no plausible reason to cut down the width of that part so as to exclude the services rendered by a medical practitioner from the ambit of the main part of Section 2(1)(*o*).

39. We may now proceed to consider the exclusionary part of the definition to see whether such service is excluded by the said part. The exclusionary part excludes from the main part service rendered (*i*) free of charge; or (*ii*) under a contract of personal service.

…

41. It is no doubt true that the relationship between a medical practitioner and a patient carries within it a certain degree of mutual confidence and trust and, therefore, the services rendered by the medical practitioner can be regarded as services of personal nature but since there is no relationship of master and servant between the doctor and the patient, the contract between the medical practitioner and his patient cannot be treated as a contract of personal service but is a contract for services and the service rendered by the medical practitioner to his patient under such a contract is not covered by the exclusionary part of the definition of 'service' contained in Section 2(1)(*o*) of the Act.

42. …There can be a contract of personal service if there is relationship of master and servant between a doctor and the person availing of his services and in that event the services rendered by the doctor to his employer would be excluded from the purview of the expression 'service' under Section 2(1)(*o*) of the Act by virtue of the exclusionary clause in the said definition.

43. The other part of exclusionary clause relates to services rendered "free of charge". The medical practitioners, government hospitals/nursing homes and private hospitals/nursing homes (hereinafter called "doctors and hospitals") broadly fall in three categories:

> (*i*) where services are rendered free of charge to everybody availing of the said services.
>
> (*ii*) where charges are required to be paid by everybody availing of the services and
>
> (*iii*) where charges are required to be paid by persons availing of services but certain categories of persons who cannot afford to pay are rendered service free of charges.

There is no difficulty in respect of the first two categories. Doctors and hospitals who render service without any charge whatsoever to every person availing of the service would not fall within the ambit of 'service' under Section 2(1)(*o*) of the Act. The payment of a token amount for registration purposes only would not alter the position in respect of such doctors and hospitals. So far as the second category is concerned, since the service is rendered on payment basis to all the persons they would clearly fall within the ambit of Section 2(1)(*o*) of the Act. The third category of doctors and hospitals do provide free service to some of the patients belonging to the poor class but the bulk of the service is rendered to the patients on payment basis. The expenses incurred for providing free service are met out of the income from the service rendered to the paying patients. The service rendered by such doctors and hospitals to paying patients undoubtedly falls within the ambit of Section 2(1)(*o*) of the Act.

44. The question for our consideration is whether the service rendered to patients free of charge by the doctors and hospitals in category (*iii*) is excluded by virtue of the exclusionary clause in Section 2(1)(*o*) of the Act. In our opinion, the question has to be answered in the negative…All persons who avail of the services by doctors and hospitals in category (*iii*) are required to be treated on the same footing irrespective of the fact that some of them pay for the service and others avail of the same free of charge. Most of the doctors and hospitals work on commercial lines and the expenses incurred for providing services free of charge to patients who are not in a position to bear the charges are met out of the income earned by such doctors and hospitals from services rendered to paying patients. The government hospitals may

not be commercial in that sense but on the overall consideration of the objectives and the scheme of the Act, it would not be possible to treat the government hospitals differently. We are of the view that in such a situation, the persons belonging to "poor class" who are provided services free of charge are the beneficiaries of the service which is hired or availed of by the "paying class". We are, therefore, of the opinion that service rendered by the doctors and hospitals falling in category (*iii*) irrespective of the fact that part of the service is rendered free of charge, would nevertheless fall within the ambit of the expression 'service' as defined in Section 2(1)(*o*) of the Act. We are further of the view that persons who are rendered free service are the 'beneficiaries' and as such come within the definition of 'consumer' under Section 2(1)(*d*) of the Act.

45. …The medical officer who is employed in the hospital renders the service on behalf of the hospital administration and if the service, as rendered by the hospital, does not fall within the ambit of Section 2(1)(*o*), being free of charge, the same service cannot be treated as service under Section 2(1)(*o*) for the reason that it has been rendered by a medical officer in the hospital who receives salary for employment in the hospital. There is no direct nexus between the payment of the salary to the medical officer by the hospital administration and the person to whom service is rendered. The salary that is paid by the hospital administration to the employee medical officer cannot be regarded as payment made on behalf of the person availing of the service or for his benefit so as to make the person availing of the service a 'consumer' under Section 2(1)(*d*) in respect of the service rendered to him. The service rendered by the employee-medical officer to such a person would, therefore, continue to be service rendered free of charge and would be outside the purview of Section 2(1)(*o*).

46. A contention has also been raised that even in the government hospitals/health centres/dispensaries where services are rendered free of charge to all the patients, the provisions of the Act shall apply because the expenses of running the said hospitals are met by appropriation from the Consolidated Fund which is raised from the taxes paid by the taxpayers. We do not agree.

47. …The tax paid by the person availing of the service at a government hospital cannot be treated as a consideration or charge for the service rendered at the said hospital and such service, though rendered free of charge, does not cease to be so because the person availing of the service happens to be a taxpayer.

48. Adverting to the individual doctors employed and serving in the hospitals, we are of the view that such doctors working in the hospitals/nursing homes/dispensaries, whether government or private — belonging to categories (*ii*) and (*iii*) above would be covered by the definition of 'service' under the Act and as such are amenable to the provisions of the Act along with the management of the hospital, etc. jointly and severally.

49. There may, however, be a case where a person has taken an insurance policy for medicare whereunder all the charges for consultation, diagnosis and medical treatment are borne by the insurance company. In such a case, the person receiving the treatment is a beneficiary of the service which has been rendered to him by the medical practitioner, the payment for which would be made by the insurance company under the insurance policy. The rendering of such service by the medical practitioner cannot be said to be free of charge and would, therefore, fall within the ambit of the expression 'service' in Section 2(1)(*o*) of the Act. So also there may be cases where as a part of the conditions of service, the employer bears the expense of medical treatment of the employee and his family members dependent on him. The service rendered to him by a medical practitioner would not be free of charge and would, therefore, constitute service under Section 2(1)(*o*).

…

55. On the basis of the above discussion, we arrive at the following conclusions:

> (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 Act.
>
> (2) The fact that medical practitioners belong to the medical profession and are subject to the disciplinary control of the Medical Council of India and/or State Medical Councils constituted under the provisions of the Indian Medical Council Act would not exclude the services rendered by them from the ambit of the Act.
>
> (3) A "contract *of* personal service" has to be distinguished from a "contract *for* personal services". In the absence of a relationship of master and servant between the patient and medical practitioner, the service rendered by a medical practitioner to the patient cannot be regarded as

service rendered under a 'contract *of* personal service'. Such service is service rendered under a "contract *for* personal services" and is not covered by exclusionary clause of the definition of 'service' contained in Section 2(1)(*o*) of the Act.

(4) The expression "contract of personal service" in Section 2(1)(*o*) of the Act cannot be confined to contracts for employment of domestic servants only and the said expression would include the employment of a medical officer for the purpose of rendering medical service to the employer. The service rendered by a medical officer to his employer under the contract of employment would be outside the purview of 'service' as defined in Section 2(1)(*o*) of the Act.

(5) Service rendered free of charge by a medical practitioner attached to a hospital/nursing home or a medical officer employed in a hospital/nursing home where such services are rendered free of charge to everybody, would not be 'service' as defined in Section 2(1)(*o*) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing home would not alter the position.

(6) Service rendered at a non-government hospital/nursing home where no charge whatsoever is made from any person availing of the service and all patients (rich and poor) are given free service — is outside the purview of the expression 'service' as defined in Section 2(1)(*o*) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing home would not alter the position.

(7) Service rendered at a non-government hospital/nursing home where charges are required to be paid by the persons availing of such services falls within the purview of the expression 'service' as defined in Section 2(1)(*o*) of the Act.

(8) Service rendered at a non-government hospital/nursing home where charges are required to be paid by persons who are in a position to pay and persons who cannot afford to pay are rendered service free of charge would fall within the ambit of the expression 'service' as defined in Section 2(1)(*o*) of the Act irrespective of the fact that the service is rendered free of charge to persons who are not in a position to pay for such services. Free service, would also be 'service' and the recipient a 'consumer' under the Act.

(9) Service rendered at a government hospital/health centre/dispensary where no charge whatsoever is made from any person availing of the services and all patients (rich and poor) are given free service — is outside the purview of the expression 'service' as defined in Section 2(1)(*o*) of the Act. The payment of a token amount for registration purpose only at the hospital/nursing home would not alter the position.

(10) Service rendered at a government hospital/health centre/dispensary where services are rendered on payment of charges and also rendered free of charge to other persons availing of such services would fall within the ambit of the expression 'service' as defined in Section 2(1)(*o*) of the Act, irrespective of the fact that the service is rendered free of charge to persons who do not pay for such service. Free service would also be 'service' and the recipient a 'consumer' under the Act.

(11) Service rendered by a medical practitioner or hospital/nursing home cannot be regarded as service rendered free of charge, if the person availing of the service has taken an insurance policy for medical care whereunder the charges for consultation, diagnosis and medical treatment are borne by the insurance company and such service would fall within the ambit of 'service' as defined in Section 2(1)(*o*) of the Act.

(12) Similarly, where, as a part of the conditions of service, the employer bears the expenses of medical treatment of an employee and his family members dependent on him, the service rendered to such an employee and his family members by a medical practitioner or a hospital/nursing home would not be free of charge and would constitute 'service' under Section 2(1)(*o*) of the Act…"

IN THE SUPREME COURT OF INDIA

Achutrao Haribhau Khodwa v. State of Maharashtra
(1996) 2 SCC 634
S.P. Bharucha and B.N. Kirpal, JJ.

A suit for damages for medical negligence was filed by the husband and children of a woman who died as a result of the complications arising out of her sterilization operation, wherein a mop was left inside her body. The suit succeeded at the trial court, but failed on appeal to the Bombay High Court. In this appeal, the Court examined whether the government doctors who attended the woman were negligent in discharge of their duties and if so, whether the State of Maharashtra could be held vicariously liable for their negligence.

Kirpal, J.: "The appellants are aggrieved by the judgment of the Aurangabad Bench of the Bombay High Court which has reversed a decree for Rs 36,000 passed by the Civil Judge, Second Division, Aurangabad, as damages on account of the death of one Chandrikabai who was the wife of Appellant 1 and the mother of Appellants 2 to 5, after she had undergone a sterilisation operation at the Civil Hospital, Aurangabad.

2. …Chandrikabai delivered a male child on 10-7-1963. As she had got herself admitted to this hospital with a view to undergo a sterilisation operation after the delivery, the said operation was performed by Respondent 2 on 13-7-1963. Soon thereafter Chandrikabai developed high fever and also had acute pain which was abnormal after such a simple operation. Her condition deteriorated further and on 15-7-1963 Appellant 1 approached Respondent 3 and one Dr Divan, PW 2, who was a well-known surgeon and was attached to the hospital, but was not directly connected with the Gynaecological Department. At the insistence of Appellant 1 Dr Divan examined Chandrikabai on 15-7-1963, and seeing her condition, he is alleged to have suggested that the sterilisation operation which had been performed should be reopened. This suggestion was not acted upon by Respondents 2 and 3 and the condition of Chandrikabai became very serious. On 19-7-1963, Dr Divan, on being called once again, reopened the wound of the earlier operation in order to ascertain the true cause of the seriousness of the ailment and to find out the cause of the worsening condition of Chandrikabai. According to the appellants, Respondents 2 and 3 assisted Dr Divan in this operation. Dr Divan, as a result of the second operation, found that a mop (towel) had been left inside the body of Chandrikabai when sterilisation operation was performed on her. It was found that there was collection of pus and the same was drained out by Dr Divan. Thereafter, the abdomen was closed and the second operation completed. Even, thereafter the condition of Chandrikabai did not improve and ultimately she expired on 24-7-1963.

3. Alleging that Chandrikabai was working as a teacher in a government school and her salary augmented the total income of the family, it was pleaded that the death of Chandrikabai was caused due to the negligence of Respondent 2 who had performed the sterilisation operation on 13-7-1963, as well as the irresponsible behaviour of Respondent 3. The appellants also alleged that the hospital lacked adequate medical aid and proper care and there was gross dereliction of duty on the part of the officers of the Government Civil Hospital which directly resulted in the death of Chandrikabai and, therefore, the appellants were entitled to recover damages from the Government of Maharashtra (Respondent 1) as well as Respondents 2 to 4. The appellants claimed total damages of Rs 1,75,000…

…

8. Two questions which arise for consideration in this appeal are whether the State of Maharashtra can be held liable for any negligence of its employees and secondly whether the respondents or any one of them acted negligently in the discharge of their duties.

9. Decisions of this Court now leave no scope for arguing that the State cannot be held to be vicariously liable if it is found that the death of Chandrikabai was caused due to negligence on the part of its employees.

10. In *State of Rajasthan v. Vidhyawati* [AIR 1962 SC 933 : 1962 Supp (2) SCR 989 : (1963) 1 MLJ (SC) 70] the question arose with regard to the vicarious liability of the State of Rajasthan… this Court held that "the State should be as much liable for tort in respect of a tortious act committed by its servant within the scope of his employment and functioning as such, as any other employer". This question again came up for consideration in *Kasturi Lal Ralia Ram Jain v. State*

of U.P. [AIR 1965 SC 1039] and which has been referred to by the High Court in the present case while coming to the conclusion that the State of Maharashtra cannot be held to be vicariously liable… This Court distinguished the decision in *Vidhyawati case* [AIR 1962 SC 933 : 1962 Supp (2) SCR 989 : (1963) 1 MLJ (SC) 70] by observing:

> "In dealing with such cases, it must be borne in mind that when the State pleads immunity against claims for damages resulting from injury caused by negligent acts of its servants, the area of employment referable to sovereign powers must be strictly determined. Before such a plea is upheld, the Court must always find that the impugned act was committed in the course of an undertaking or employment which is referable to the exercise of sovereign power, or to the exercise of delegated sovereign power…"

Explaining the distinction between the two types of cases, it was also observed as follows:

> "It is not difficult to realize the significance and importance of making such a distinction particularly at the present time when, in pursuit of their welfare ideal, the Government of the States as well as the Government of India naturally and legitimately enter into many commercial and other undertakings and activities which have no relation with the traditional concept of governmental activities in which the exercise of sovereign power is involved. It is necessary to limit the area of these affairs of the State in relation to the exercise of sovereign power, so that if acts are committed by government employees in relation to other activities which may be conveniently described as non-governmental or non-sovereign, citizens who have a cause of action for damages should not be precluded from making their claim against the State. That is the basis on which the area of the State immunity against such claims must be limited; and this is exactly what has been done by this Court in its decision in the case of *State of Rajasthan* [AIR 1962 SC 933 : 1962 Supp (2) SCR 989 : (1963) 1 MLJ (SC) 70] ."

Two recent decisions where the State has been held to be vicariously liable on account of the negligent acts of its employees are those of *N. Nagendra Rao and Co. v. State of A.P.* [(1994) 6 SCC 205 : 1994 SCC (Cri) 1609] and *State of Maharashtra v. Kanchanmala Vijaysing Shirke* [(1995) 5 SCC 659 : 1995 SCC (Cri) 1002 : JT (1995) 6 SC 155] . In *Nagendra Rao case* [(1994) 6 SCC 205 : 1994 SCC (Cri) 1609]…, this Court while allowing the appeal observed as follows: (SCC pp. 235-36, para 25)

> "In Welfare State, functions of the State are not only defence of the country or administration of justice or maintaining law and order but it extends to regulating and controlling the activities of people in almost every sphere, educational, commercial, social, economic, political and even marital. The demarcating line between sovereign and non-sovereign powers for which no rational basis survives has largely disappeared. Therefore, barring functions such as administration of justice, maintenance of law and order and repression of crime etc. which are among the primary and inalienable functions of a constitutional Government, the State cannot claim any immunity. The determination of vicarious liability of the State being linked with negligence of its officers, if they can be sued personally for which there is no dearth of authority and the law of misfeasance in discharge of public duty having marched ahead, there is no rationale for the proposition that even if the officer is liable the State cannot be sued. The liability of the officer personally was not doubted even in *Viscount Canterbury* [*Viscount Canterbury v. Attorney General*, 1 PH 306 : 41 ER 648] . But the Crown was held immune on doctrine of sovereign immunity. Since the doctrine has become outdated and sovereignty now vests in the people, the State cannot claim any immunity and if a suit is maintainable against the officer personally, then there is no reason to hold that it would not be maintainable against the State."

A similar view has been taken in *Kanchanmala Vijaysing case* [(1995) 5 SCC 659 : 1995 SCC (Cri) 1002 : JT (1995) 6 SC 155]…

11. The High Court observed that the Government cannot be held liable in tort for tortious acts committed in a hospital maintained by it because it considered that maintaining and running a hospital was an exercise of the State's sovereign power. We do not think that this conclusion is correct. Running a hospital is a welfare activity undertaken by the Government but it is not an exclusive function or activity of the Government so as to be classified as one which could be regarded as being in exercise of its sovereign power. In *Kasturi Lal case* [AIR 1965 SC 1039] itself, in the passage which

has been quoted hereinabove, this Court noticed that in pursuit of the welfare ideal the Government may enter into many commercial and other activities which have no relation to the traditional concept of governmental activity in exercise of sovereign power. Just as running of passenger buses for the benefit of general public is not a sovereign function, similarly the running of a hospital, where the members of the general public can come for treatment, cannot also be regarded as being an activity having a sovereign character. This being so, the State would be vicariously liable for the damages which may become payable on account of negligence of its doctors or other employees.

12. Before considering whether the respondents in the present case could be held to be negligent, it will be useful to see as to what can be regarded as negligence on the part of a doctor. The test with regard to the negligence of a doctor was laid down in *Bolam v. Friern Hospital Management Committee* [(1957) 1 WLR 582 : (1957) 2 All ER 118] . It was to the effect that a doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. This principle in *Bolam case* [(1957) 1 WLR 582 : (1957) 2 All ER 118] has been accepted by the House of Lords in England as applicable to diagnosis and treatment. (See *Sidaway v. Board of Governors of Bethlem Royal Hospital* [1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643, HL] (AC at 881). Dealing with the question of negligence, the High Court of Australia in *Rogers v. Whitaker* [(1993) 109 ALR (sic)] has held that the question is not whether the doctor's conduct accords with the practice of a medical profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court to decide and the duty of deciding it cannot be delegated to any profession or group in the community. It would, therefore, appear that the Australian High Court has taken a somewhat different view than the principle enunciated in *Bolam case* [(1957) 1 WLR 582 : (1957) 2 All ER 118] . This Court has had an occasion to go into this question in the case of *Laxman Balkrishna Joshi (Dr) v. Dr Trimbak Bapu Godbole* [AIR 1969 SC 128 : (1969) 1 SCR 206 : 71 Bom LR 236] . In that case the High Court had held that the death of the son of the claimant was due to the shock resulting from reduction of the patient's fracture attempted by the doctor without taking the elementary caution of giving anaesthetic. In this context, with reference to the duties of the doctors to the patient, this Court, in appeal, observed as follows:

> "The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the 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 give 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."

13. The above principle was again applied by this Court in the case of *A.S. Mittal* v. *State of U.P.* [(1989) 3 SCC 223 : 1989 SCC (Cri) 539 : AIR 1989 SC 1570] In that case irreparable damage had been done to the eyes of some of the patients who were operated upon at an eye camp. Though this Court refrained from deciding, in that particular case, whether the doctors were negligent, it observed: (SCC pp. 230-31, para 19)

> "A mistake by a medical practitioner which no reasonably competent and a careful practitioner would have committed is a negligent one."

The Court also took note that the law recognises the dangers which are inherent in surgical operations and that mistakes will occur, on occasions, despite the exercise of reasonable skill and care. The Court further quoted *Street on Torts* (1983) (7th Edn.) wherein it was stated that the doctrine of *res ipsa loquitur* was attracted:

> " … Where an unexplained accident occurs from a thing under the control of the defendant, and medical or other expert evidence shows that such accidents would not happen if proper care were used, there is at least evidence of negligence for a jury."

The latest case to which reference can be made is that of *Indian Medical Assn. v. V.P. Shantha* [(1995) 6 SCC 651] . The question which arose in this case was whether the Consumer Protection Act, 1986, applied to medical practitioners, hospitals and nursing homes. It was held in this case that medical practitioners were not immune from a claim for damages on the ground of negligence. The Court also approved a passage from Jackson and Powell on *Professional Negligence* and held that:

> "(T)he 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."

14. The skill of medical practitioners differs from doctor to doctor. The very nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession and the court finds that he has attended on the patient with due care, skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence.

15. In cases where the doctors act carelessly and in a manner which is not expected of a medical practitioner, then in such a case an action in torts would be maintainable. As held in *Laxman case* [AIR 1969 SC 128 : (1969) 1 SCR 206: 71 Bom LR 236] by this Court, a medical practitioner has various duties towards his patient and he must act with a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. This is the least which a patient expects from a doctor.

16. In the present case the facts speak for themselves. Negligence is writ large…In a case like this the doctrine of *res ipsa loquitur* clearly applies. Chandrikabai had had a minor operation on 13-7-1963 and due to the negligence of Respondent 2 a mop (towel) was left inside her peritoneal cavity. It is true that in a number of cases when foreign bodies are left inside the body of a human being either deliberately, as in the case of orthopaedic operations, or accidentally no harm may befall the patient, but it also happens that complications can arise when the doctor acts without due care and caution and leaves a foreign body inside the patient after performing an operation and it suppurates. The formation of pus leaves no doubt that the mop left in the abdomen caused it, and it was the pus formation that caused all the subsequent difficulties. There is no escape from the conclusion that the negligence in leaving the mop in Chandrikabai's abdomen during the first operation led, ultimately, to her death…Under these circumstances, and in the absence of any valid explanation by the respondents which would satisfy the Court that there was no negligence on their part, we have no hesitation in holding that Chandrikabai died due to negligence of Respondents 2 and 3.

17. Even if it be assumed that it is the second operation performed by Dr Divan which led to peritonitis, as has been deposed to by Dr Purandare, the fact still remains that but for the leaving of the mop inside the peritoneal cavity, it would not have been necessary to have the second operation. Assuming even that the second operation was done negligently or that there was lack of adequate care after the operation which led to peritonitis, the fact remains that Dr Divan was an employee of Respondent 1 and the State must be held to be vicariously liable for the negligent acts of its employees working in the said hospital. The claim of the appellants cannot be defeated merely because it may not have been conclusively proved as to which of the doctors employed by the State in the hospital or other staff acted negligently which caused the death of Chandrikabai. Once death by negligence in the hospital is established, as in the case here, the State would be liable to pay the damages. In our opinion, therefore, the High Court clearly fell in error in reversing the judgment of the trial court and in dismissing the appellants' suit.

18. For the aforesaid reasons, this appeal is allowed…"

IN THE SUPREME COURT OF INDIA

State of Haryana v. Santra
(2000) 5 SCC 182
S. Saghir Ahmad and D.P. Wadhwa, JJ.

The petitioner became pregnant despite having a sterilization operation under a state programme to promote sterilization. On examination, it was revealed that her operation was "incomplete" as her left fallopian tube had not been operated upon. She was advised that termination of pregnancy could pose risk to her life. A suit for recovery of damages alleging negligence on part of the doctor was decreed in her favour. Subsequently, appeals filed by each of the parties against the order of the trial court were dismissed. The State then appealed to the High Court of Punjab and Haryana which did not succeed. In this special leave petition filed by the State, the issue before the Supreme Court was whether the doctor and the State could be held liable if the sterilization operation fails on account of the doctor's negligence.

Ahmad, J.: "…

3. Smt Santra, the victim of the medical negligence, filed a suit for recovery of Rs 2 lakhs as damages for medical negligence, which was decreed for a sum of Rs 54,000 with interest at the rate of 12 per cent per annum from the date of institution of the suit till the payment of the decretal amount...Both the appeals — one filed by the State of Haryana and the other by Smt Santra were dismissed. The second appeal filed by the State of Haryana was summarily dismissed by the Punjab & Haryana High Court on 3-8-1999. It is in these circumstances that the present special leave petition has been filed in this Court.

4. The "sterilisation scheme", admittedly, was launched by the Haryana Government and taking advantage of that scheme, Smt Santra approached the Chief Medical Officer, Gurgaon, for her sterilisation in 1988…Smt Santra was assured that full, complete and successful sterilisation operation had been performed upon her and she would not conceive a child in future. But despite the operation, she conceived. When she contacted the Chief Medical Officer and other doctors of the General Hospital, Gurgaon, she was informed that she was not pregnant. Two months later when the pregnancy became apparent, she again approached those doctors who then told her that her sterilisation operation was not successful. Dr Sushil Kumar Goyal, who was examined as DW 2, stated that the operation related only to the right Fallopian tube and the left Fallopian tube was not touched, which indicates that "complete sterilisation" operation was not done. She requested for an abortion, but was advised not to go in for abortion as the same would be dangerous to her life. She ultimately gave birth to a female child. Smt Santra already had seven children and the birth of a new child put her to unnecessary burden of rearing up the child as also all the expenses involved in the maintenance of that child, including the expenses towards her clothes and education.

…

6. The trial court as also the lower appellate court both recorded concurrent findings of fact that the sterilisation operation performed upon Smt Santra was not "complete" as in that operation only the right Fallopian tube was operated upon while the left tube was left untouched. The courts were of the opinion that this exhibited negligence on the part of the Medical Officer who performed the operation. Smt Santra, in spite of the unsuccessful operation, was informed that the sterilisation operation was successful and that she would not conceive any child in future. The plea of estoppel raised by the defendants was also rejected…

…

9. Learned counsel appearing on behalf of the State of Haryana has contended that the negligence of the Medical Officer in performing the unsuccessful sterilisation operation upon Smt Santra would not bind the State Government and the State Government would not be liable vicariously for any damages to Smt Santra. It was also claimed that the expenses awarded for rearing up the child and for her maintenance could not have been legally decreed as there was no element of "tort" involved in it nor had Smt Santra suffered any loss which could be compensated in terms of money.

…

19. Family planning is a national programme. It is being implemented through the agency of various government hospitals and health centres and at some places through the agency of the Red Cross…The implementation of the programme is thus directly in the hands of the government officers, including Medical Officers involved in the family

planning programmes. The Medical Officers entrusted with the implementation of the family planning programme cannot, by their negligent acts in not performing the complete sterilisation operation, sabotage a scheme of national importance. The people of the country who cooperate by offering themselves voluntarily for sterilisation reasonably expect that after undergoing the operation they would be able to avoid further pregnancy and consequent birth of an additional child.

20. If Smt Santra, in these circumstances, had offered herself for complete sterilisation, both the Fallopian tubes should have been operated upon. The doctor who performed the operation acted in a most negligent manner as the possibility of conception by Smt Santra was not completely ruled out as her left Fallopian tube was not touched. Smt Santra did conceive and gave birth to an unwanted child.

21. Who has to bear the expenses in bringing up the "unwanted child", is the question which is to be decided by us in this case.

22. The amount of Rs 54,000 which has been decreed by the courts below, represents the amount of expenses which Smt Santra would have to incur at the rate of Rs 3000 per annum in bringing up the child up to the age of puberty.

23. The domestic legal scenario on this question appears to be silent, except one or two stray decisions of the High Courts, to which a reference shall be made presently.

…

35. In *State of M.P. v. Asharam* [1997 ACJ 1224 (MP)] the High Court allowed the damages on account of medical negligence in the performance of a family planning operation on account of which a daughter was born after fifteen months of the date of the operation.

36. No other decision of any High Court has come to our notice where damages were awarded on account of a failed sterilisation operation.

37. Ours is a developing country where the majority of the people live below the poverty line. On account of the ever-increasing population, the country is almost at the saturation point so far as its resources are concerned. The principles on the basis of which damages have not been allowed on account of failed sterilisation operation in other countries either on account of public policy or on account of pleasure in having a child being offset against the claim for damages cannot be strictly applied to Indian conditions so far as poor families are concerned. The public policy here professed by the Government is to control the population and that is why various programmes have been launched to implement the State-sponsored family planning programmes and policies. Damages for the birth of an unwanted child may not be of any value for those who are already living in affluent conditions but those who live below the poverty line or who belong to the labour class, who earn their livelihood on a daily basis by taking up the job of an ordinary labour, cannot be denied the claim for damages on account of medical negligence.

…

42. Having regard to the above discussion, we are positively of the view that in a country where the population is increasing by the tick of every second on the clock and the Government had taken up family planning as an important programme for the implementation of which it had created mass awakening for the use of various devices including sterilisation operation, the doctor as also the State must be held responsible in damages if the sterilisation operation performed by him is a failure on account of his negligence, which is directly responsible for another birth in the family, creating additional economic burden on the person who had chosen to be operated upon for sterilisation.

43. The contention as to the vicarious liability of the State for the negligence of its officers in performing the sterilisation operation cannot be accepted in view of the law settled by this Court in *N. Nagendra Rao & Co. v. State of A.P.* [(1994) 6 SCC 205 : 1994 SCC (Cri) 1609 : AIR 1994 SC 2663] , *Common Cause, A Regd. Society v. Union of India* [(1999) 6 SCC 667 : 1999 SCC (Cri) 1196 : AIR 1999 SC 2979] and *Achutrao Haribhau Khodwa v. State of Maharashtra* [(1996) 2 SCC 634 : 1996 ACJ 505] . The last case, which related to the fallout of a sterilisation operation, deals, like the two previous cases, with the question of vicarious liability of the State on account of medical negligence of a doctor in a government hospital. The theory of sovereign immunity was rejected.

44. Smt Santra, as already stated above, was a poor lady who already had seven children. She was already under considerable monetary burden. The unwanted child (girl) born to her has created additional burden for her on account of the negligence of the doctor who performed the sterilisation operation upon her and, therefore, she is clearly entitled to claim full damages from the State Government to enable her to bring up the child at least till she attains puberty."

IN THE HIGH COURT OF MADHYA PRADESH

State of M.P. v. Smt. Sundari Bai
AIR 2003 MP 284
S.P. Khare, J.

The plaintiff/appellant underwent a sterilization procedure at a government hospital. Considering her specific health needs, the doctor adopted ligation method for sterilization instead of section method. Six years later, the plaintiff delivered a child and filed a suit against the doctor and State Government seeking compensation for failed sterilization. The trial court held that the doctor was negligent in adopting the ligation method and imposed vicarious liability on the State Government. In this appeal, the High Court examined whether the doctor had conducted the sterilization procedure with "reasonable degree of care and skill".

Khare, J.: "**1.** This is first appeal under section 96, Civil Procedure Code by defendant No. 2 State of Madhya Pradesh against the judgment and decree by which compensation of Rs. 50,000/- has been awarded to the plaintiff for "failure of sterilisation".

2. It is no longer in dispute that plaintiff Sundaribai had two sons. At the time of the birth of second son on 27-8-1980 she got her "sterilisation" done so that there is no further pregnancy. The operation was performed by defendant No. 1 Dr. R. Rathore, Assistant Surgeon, Ashta in the Government hospital "by ligation method". She conceived again in the year 1986 and gave birth to a female child on 8-12-1986.

3. The plaintiff's case is that she is a poor and illiterate lady. She was told by the lady doctor that she would not have any further pregnancy. According to the plaintiff the defendant No. 1 acted negligently in performing the tubectomy operation. She claimed Rs. 50,000/- as compensation for "failed sterilisation" for expenses incurred in the delivery, for rearing the female child and her marriage, against the doctor and the State Government.

4. The case of the defendants is that the sterilization was done by "tying the fallopian tubes" on account of personal peculiar physical condition of the plaintiff. Her physical condition could not allow the cutting of the fallopian tubes. She was advised to avoid hard work, physical strain and sexual intercourse for sometime. It has been denied that there was any negligence on the part of the doctor. According to the defendants the sterilisation failed because of the act of the plaintiff herself. It is scientifically and universally recognised that the sterilisation operation can fail in some cases…

…

6. In this appeal it has been argued that the finding of the trial Court that there was negligence of the doctor is not correct. It is submitted that "ligation Method" is one of the recognised modes of sterilisation and if keeping in view the personal and physical condition of the plaintiff the doctor in her judgment adopted this method it cannot be held by the Courts that she acted negligently.

…

10. From the evidence of the lady doctor it is found that she adopted one of the recognised methods of sterilisation and that was "ligation method". She has given reasons for not cutting the fallopian tubes. According to her testimony, there has been no failure of sterilization in any other case except that of the plaintiff. The testimony of the lady doctor is reliable. It cannot be said that she was negligent because she did not adopt the section method of sterilisation. She was an experienced doctor and she could exercise her discretion as to which method she should adopt for the purpose of sterilization. As already stated no evidence has been adduced by the plaintiff to prove negligence of the doctor except her own testimony.

11. The trial Court has held defendant No. 1 Dr. Rathore negligent as she did not adopt the section method for sterilization. The view taken by the trial Court is not correct. It was for the doctor to decide which method of sterilisation she should adopt in the case of the plaintiff. The trial Court in para 23 of its judgment has accepted the proposition that there is a possibility of failure of the sterilisation operation. The trial Court has not rejected the evidence of the lady doctor on this point that she has performed a large number of sterilisation operations (about 1500 - 25% of 6000) through "ligation method" and there has been no failure in any other case and therefore this version of the lady doctor is true. Even in case of the plaintiff the ligation method was successful for about six years and during this period she had no conception…

12.*William's Obstetrics* 21st Edition pages 1556 to 1560 deal with "sterilization". This edition which is available at present is of the year 1997. In the present case sterilization was done in the year 1980 and at that time as per 1971 edition the ligation method of tubal sterilization was quite acceptable. Now more safe techniques have been developed. It is stated at

page 1559 of 1997 edition: "No method of tubal sterilization is without failure"…A similar conclusion was reached by the American College of Obstetricians and Gynecologists (1996), which stated…"Finally, the lifetime increased cumulative failure rates overtime are supportive that failures *after one year are not likely due to technical errors*". Thus, according to this authoritative book the failure of tubal sterilization is not necessarily on account of negligence of the doctor. In the present case the tubal sterilization failed after six years and it cannot be attributed to the negligence of the doctor.

13. The learned counsel for the appellant has cited the decision of the Supreme Court in *State of Haryana v. Santra*, (2000) 5 SCC 182. In that case the plaintiff having seven children under went sterilization operation. It was found that in her case the right fallopian tube was operated upon and the left fallopian tube was left untouched. The negligence of the doctor was writ large as it was necessary to operate both fallopian tubes to avoid further pregnancy. It is because of this negligence *per se* the damages were awarded to the plaintiff. The Supreme Court observed that every doctor who enters the medical profession has a duty to act with a "reasonable degree of care and skill". This is what is known as "implied undertaking" by member of the medical profession that he would use a fair reasonable and competent degree of skill. The test known as "Bolam test" laid down in *Bolam v. Frien Hospital Management Committee*, (1957) 2 All. E.R. 118 has been cited with approval. In this case the law was summed up as under: "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 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 …… in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. ….there may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards then he is not negligent."

14. The decision of the House of Lords in *Whitehouse v. Jordan*, (1981) 1 All. E.R. 267 has also been relied upon in which the legal position has been stated as: "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 (such) a man, acting with ordinary care, might have made, then it is not negligence."

15. The Supreme Court said in *Laxman v. Trimbak*, AIR 1969 SC 128 : "Neither the very highest nor very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires". In *Vinitha Ashok*v. *Lakshmi Hospital*, (2001) 8 SCC 731 the entire case law has been dealt with and it has been concluded that the doctor is not liable for negligence if the course adopted by him is "reasonable" and his view is not "illogical".

16. Now examining the facts of the present case on the touchstone of the above mentioned principles it can be safely held that there was no negligence on the part of the doctor. In the present case the plaintiff had two sons when the steriliasation was performed. Her physical condition was not good. The "ligation method" which is a well recognised mode of sterilization was adopted. This method was used by the doctor in hundreds of cases and there was no failure of this mode. Even in case of the plaintiff this method worked well for six years and the pregnancy was prevented. Thus the doctor acted with reasonable degree of care and skill. There were more than one "perfectly proper standards" and if the doctor chose one then she cannot be said to be negligent. There might have been an error of judgment while acting with ordinary care and skill and that cannot be equated with negligence. It is one thing to say that it would have been better if "section method" had been chosen for sterilisation but the adoption of "ligation method" on the facts of the present case is not negligence per se. The defendant No. 1 though quite experienced was working in a Primary Health Centre and she used a fair, reasonable and competent degree of skill.

…

19. It is not necessary for the doctor to warn the plaintiff of the "risk of failure of sterilisation" because it is well known that there is such failure though in very limited number of cases. It is not necessary to give the warning of something which is well known and well recognised. In *Gold v. Haringey Health Authority*, (1988) 1 QB 481 a doctor was not held negligent in failing to warn the plaintiff of the failure rate for female sterilisation.

20. A doctor does not give a contractual warranty. He is not an insurer against all possible risks. He or she does not provide insurance that there would be no pregnancy after sterilisation operation. As demonstrated above there is a chance of sterile being turned into fertile even after the operation has been done with due care and caution. A doctor is not liable in negligence because someone of greater skill and knowledge would have prescribed different treatment or "operated in a different way". She has to show only a reasonable standard of care. She cannot be held guilty for error of judgment. Considerable deference is paid to the practices of the professions (particularly medical profession)

as established by expert evidence and the Court should not attempt to put itself in the shoes of the surgeon or other professional man. In the present case the plaintiff had two sons only. A female baby was born to her after six years. She should accept her with grace as gift of God. The parents are primarily liable to give birth to this child. They should not hold the doctor liable when they have been blessed with this baby. She should not have a feeling that she is an unwanted child. The birth of this baby should be considered a blessing and cause for rejoicing. A healthy female baby after the two sons, a lovely creature, must have brought decency, discipline and sobriety in the family. The doctor not being negligent cannot be fastened with liability to pay damages and therefore the Government is also not vicariously liable.

21. In the result, the judgment and decree of the trial Court are set aside and the suit of the plaintiff for compensation of Rs. 50,000/- is dismissed."

IN THE SUPREME COURT OF INDIA

State of Punjab v. Shiv Ram & Ors.
(2005) 7 SCC 1
R.C. Lahoti, C.J., and C.K. Thakker and P.K. Balasubramanyan, JJ.

A woman became pregnant after undergoing a sterilization operation and chose to continue the pregnancy as she considered abortion to be a sin. She filed a suit for claiming compensation against the doctor and State, since she had undergone a tubectomy procedure in response to the State's publicity campaign encouraging sterilization. The procedure was conducted by a doctor employed by the State government. The trial court and the first appellate court imposed vicarious liability on the State solely on the ground that the woman became pregnant despite having undergone the sterilization operation. A second appeal was summarily dismissed by the High Court. In this appeal, the Supreme Court examined whether the failure of sterilization was attributable to negligence on part of the doctor and ruled on the correctness of the approach of the courts below.

Lahoti, C.J.: "The plaintiff-respondents, respectively the husband and the wife, filed a suit against the State of Punjab, the appellant before us and a lady surgeon who was in the State Government's employment at the relevant time, for recovery of damages to the tune of Rs 3,00,000 on account of a female child having been born to them in spite of the wife Respondent 2 having undergone a tubectomy operation performed by the lady surgeon… After serving a notice under Section 80 of the Code of Civil Procedure, a suit for recovery of damages was filed on 15-5-1992 attributing the birth of the child to carelessness and negligence of the lady surgeon. The plaint alleged *inter alia* that the respondents considered abortion to be a sin and that is why after knowing of the conception they did not opt for abortion.

…

4. …However, the two courts have proceeded on the reasoning that on the birth of a child to a woman who was allured into undergoing sterilisation operation by the State in pursuance of its Family Planning Schemes, the State was liable to compensate for the consequences of the operation having failed. The suit was decreed for Rs 50,000 with interest and costs. The decree for compensation passed by the trial court has been upheld by the first appellate court. The second appeal preferred by the State has been summarily dismissed.

…

6. Very recently, this Court has dealt with the issues of medical negligence and laid down principles on which the liability of a medical professional is determined generally and in the field of criminal law in particular. Reference may be had to *Jacob Mathew v. State of Punjab* [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] . The Court has approved the test [**Ed.**: At p. 19, para 19.] as laid down in *Bolam* v. *Friern Hospital Management Committee* [(1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)] popularly known as *Bolam's test*, in its applicability to India.

7. The relevant principles culled out from the case of *Jacob Mathew* [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] read as under: (SCC pp. 32-33, para 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'.

(*2*) … 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. 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.…

(*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 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."

This Court has further held in *Jacob Mathew case* [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] : (SCC p. 24, para 33)

"*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."

8. The plaintiffs have not alleged that the lady surgeon who performed the sterilisation operation was not competent to perform the surgery and yet ventured into doing it. It is neither the case of the plaintiffs, nor has any finding been arrived at by any of the courts below that the lady surgeon was negligent in performing the surgery. The present one is not a case where the surgeon who performed the surgery has committed breach of any duty cast on her as a surgeon. The surgery was performed by a technique known and recognised by medical science. It is a pure and simple case of sterilisation operation having failed though duly performed. The learned Additional Advocate General has also very fairly not disputed the vicarious liability of the State, if only its employee doctor is found to have performed the surgery negligently and if the unwanted pregnancy thereafter is attributable to such negligent act or omission on the part of the employee doctor of the State.

9. The learned Advocate General has brought to our notice a number of textbooks on gynaecology. We refer to some of them.

10. In *Jeffcoate's Principles of Gynaecology*, revised by V.R. Tindall, MSc, MD, FRCSE, FRCOG, Professor of Obstetrics and Gynaecology, University of Manchester (5th Edn.) published by Butterworth Heinemann, the following techniques of female sterilisation are stated:…

11. Dealing with reliability of the sterilisation procedures performed and commonly employed by gynaecologists, the textbook states (at p. 621):

"*Reliability*

The only sterilisation procedures in the female which are both satisfactory and reliable are: resection or destruction of a portion of both fallopian tubes; and hysterectomy. *No method, however, is absolutely reliable and pregnancy is reported after subtotal and total hysterectomy, and even after hysterectomy with bilateral salpingectomy*. The explanation of these extremely rare cases is a persisting communication between the ovary or tube and the vaginal vault.

Even when tubal occlusion operations are competently performed and all technical precautions are taken, intrauterine pregnancy occurs subsequently in 0.3 per cent of cases. This is because an ovum gains access to spermatozoa through a recanalised inner segment of the tube.

> There is clinical impression that tubal resection operations are more likely to fail when they are carried out at the time of caesarean section than at any other time. The fact that they occasionally fail at any time has led many gynaecologists to replace the term 'sterilisation' by 'tubal ligation' or 'tubal resection' in talking to the patient and in all records. This has real merit from the medicolegal standpoint."
>
> (underlining [italicised.] by us)

…

13. In *The Essentials of Contraceptive Technology*, written by four doctors and published by the Center for Communication Programs, the Johns Hopkins School of Public Health in July 1997, certain questions and answers are stated. Questions 5 and 6 and their answers, which are relevant for our purpose, read as under:

> "*5. Will female sterilisation stop working after a time? Does a woman who had a sterilisation procedure ever have to worry about getting pregnant again*?
>
> Generally, no. Female sterilisation should be considered permanent. Failure rates are probably higher than previously thought however. A major new US study found that *the risk of pregnancy within 10 years after sterilisation is about 1.8 per 100 women — about 1 in every 55 women*. The risk of sterilisation failure is greater for younger women because they are more fertile than older women. Also, some methods of blocking the tubes work better than others. Methods that cut away part of each tube work better than spring clips or bipolar electrocoagulation (electric current). Effectiveness also depends on the skill of the provider.
>
> The same US study found that 1 of every 3 pregnancies after sterilisation was ectopic. *If a woman who has had sterilisation ever thinks that she is pregnant or has an ectopic pregnancy, she should seek help right away*.
>
> (underlining [italicised] by us)
>
> *6. Pregnancy after female sterilisation is rare but why does it happen at all*?
>
> The most common reason is that the woman was *already pregnant at the time of sterilisation*. Pregnancy can also occur if the provider confused another structure in the body with the fallopian tubes and blocked or cut the wrong place. In other case pregnancy results because clips on the tubes come open, because the ends of the tubes grow back together, or because abnormal openings develop in the tube, allowing sperm and egg to meet."

14. In the newsletter "Alert" September 2000 Issue, Prof. (Dr.) Gopinath N. Shenoy writes:

> "Female sterilisation can be done by many methods/techniques, which are accepted by medical professionals all over the world. It is also *an accepted fact that none of these methods/techniques are cent per cent 'failure free'. This 'failure rate' may vary from method to method*. A doctor is justified in choosing one method to the exclusion of the others and he cannot be faulted for his choice if his choice is based on reasonable application of mind and is not 'palpably' wrong. A doctor has discretionary powers to choose the method/technique of sterilisation he desires to adopt."
>
> (emphasis supplied)

…

16. In *Medico-legal Aspects in Obstetrics and Gynaecology*, edited by three doctors, Chapter 18, deals with medico-legal problems in sterilisation operations. It is stated therein that there are several methods of female sterilisation of which one that will suit the patient and the surgeon/gynaecologist should be selected. In India, Pomeroy's method is widely practised. Other methods include Madlener's, Irving's, Uchida's methods and so on. The text further states that failure is one of the undesirous outcomes of sterilisation. The overall incidence of failure in tubectomy is 0.4 per 100 women per year. The text describes the following events wherefrom sterilisation failure usually results:…

17. It is thus clear that there are several alternative methods of female sterilisation operation which are recognised by medical science of today. Some of them are more popular because of being less complicated, requiring minimal body invasion and least confinement in the hospital. However, none is foolproof and no prevalent method of sterilisation guarantees 100% success. The causes for failure can well be attributable to the natural functioning of the human body and not necessarily attributable to any failure on the part of the surgeon. Authoritative textbooks on gynaecology and empirical researches which have been carried out recognise the failure rate of 0.3% to 7% depending on the technique

chosen out of the several recognised and accepted ones. The technique which may be foolproof is the removal of the uterus itself but that is not considered advisable. It may be resorted to only when such procedure is considered necessary to be performed for purposes other than merely family planning.

18. An English decision, *Eyre v. Measday* [(1986) 1 All ER 488 (CA)] is very near to the case at hand. The facts of the case were that in 1978, the plaintiff and her husband decided that they did not wish to have any more children. The plaintiff consulted the defendant gynaecologist with a view to undergoing a sterilisation operation. The defendant explained to the couple the nature of the particular operation he intended to perform, emphasising that it was irreversible. He stated that the operation "must be regarded as a permanent procedure" but he did not inform the plaintiff that there was a small risk (less than 1%) of pregnancy occurring following the operation. Consequently, both the plaintiff and her husband believed that the result of the operation would be to render her absolutely sterile and incapable of bearing further children. In 1979 the plaintiff became pregnant and gave birth to a child. The plaintiff brought an action against the defendant for damages, *inter alia*, for breach of contract, contending that his representation that the operation was irreversible and his failure to warn her of the minute risk of the procedure being unsuccessful, amounted to breach of a contractual term, or express or implied collateral warranty, to render her irreversibly sterile. The Judge dismissed her claim and the plaintiff appealed to the Court of Appeal.

19. The Court held: (All ER p. 488*f-h*)

> "(*1*) The contract undertaken by the defendant was to carry out a particular type of operation rather than to render the plaintiff absolutely sterile. Furthermore, the defendant's representations to the plaintiff that the operation was 'irreversible' did not amount to an express guarantee that the operation was bound to achieve its acknowledged object of sterilising the plaintiff. On the facts, it was clear that the representations meant no more than that the operative procedure in question was incapable of being reversed.
>
> (*2*) Where a doctor contracted to carry out a particular operation on a patient and a particular result was expected, the court would imply into the contract between the doctor and the patient a term that the operation would be carried out with reasonable care and skill, but would be slow to imply a term or unqualified collateral warranty that the expected result would actually be achieved, since it was probable that no responsible medical man would intend to give such a warranty. On the facts, no intelligent lay bystander could have reasonably inferred that the defendant was intending to give the plaintiff a guarantee that after the operation she would be absolutely sterile and the fact that she believed that this would be the result was irrelevant."

20. The appeal was dismissed. The Court of Appeal, upheld the finding of the trial Judge that the risk of pregnancy following such a procedure to which the plaintiff was subjected is described as very small. It is of the order of 2 to 6 in every 1000. There is no sterilisation procedure which is entirely without such a risk.

21. Slade, L.J., stated in his opinion that: (All ER p. 495*f-h*)

> "[I]n the absence of any express warranty, the court should be slow to imply against a medical man an unqualified warranty as to the results of an intended operation, for the very simple reason that, objectively speaking, it is most unlikely that a responsible medical man would intend to give a warranty of this nature. Of course, objectively speaking, it is likely that he would give a guarantee that he would do what he had undertaken to do with reasonable care and skill; but it is quite another matter to say that he has committed himself to the extent suggested in the present case."

22. Purchas, L.J., stated in his opinion that: (All ER p. 497*a-c*)

> "It is true that as a matter of deliberate election the defendant did not, in the course of describing the operation which he was recommending, disclose that there was a very small risk, one might almost say an insignificant risk, that the plaintiff might become pregnant. In withholding this information it must be borne in mind, first that the defendant must have believed that the plaintiff would be sterile, second that the chances were extremely remote that the operation would be unsuccessful, third that in withholding this information the defendant was following a practice acceptable to current professional standards and was acting in the best interests of the plaintiff, and, fourth that no allegation of negligence in failing to give this information to the plaintiff is pursued any longer in this case. There are, therefore, in my judgment, no grounds for asserting that the result would necessarily be 100% successful."

23. In *Thake v. Maurice* [(1986) 1 All ER 497 : (1986) 2 WLR 337 : 1986 QB 644 (CA)] the claim for damages was founded on contract and not in tort. The Court of Appeal firmly rejected the possibility of an enforceable warranty. Neill, L.J. said: (All ER p. 510*h*)

> "The reasonable man would have expected the defendant to exercise all the proper skill and care of a surgeon in that speciality; he would not … have expected the defendant to give a guarantee of 100% success."

24. Nourse, L.J. said: (All ER p. 512*f*)

> "Of all sciences medicine is one of the least exact. In my view a doctor cannot be objectively regarded as guaranteeing the success of any operation or treatment unless he says as much in clear and unequivocal terms."

25. We are, therefore, clearly of the opinion that merely because a woman having undergone a sterilisation operation became pregnant and delivered a child, the operating surgeon or his employer cannot be held liable for compensation on account of unwanted pregnancy or unwanted child. The claim in tort can be sustained only if there was negligence on the part of the surgeon in performing the surgery. The proof of negligence shall have to satisfy *Bolam's test*. So also, the surgeon cannot be held liable in contract unless the plaintiff alleges and proves that the surgeon had assured 100% exclusion of pregnancy after the surgery and was only on the basis of such assurance that the plaintiff was persuaded to undergo surgery. As noted in various decisions which we have referred to hereinabove, ordinarily a surgeon does not offer such guarantee.

26. The cause of failure of the sterilisation operation may be obtained from laparoscopic inspection of uterine tubes, or by x-ray examination, or by pathological examination of the materials removed at a subsequent operation of re-sterilisation…

27. Mrs K. Sarada Devi, the learned counsel appearing for the plaintiff-respondents placed reliance on a two-Judge Bench decision of this Court in *State of Haryana v. Santra* [(2000) 5 SCC 182 : JT (2000) 5 SC 34] wherein this Court has upheld the decree awarding damages for medical negligence on account of the lady having given birth to an unwanted child on account of failure of sterilisation operation. The case is clearly distinguishable and cannot be said to be laying down any law of universal application. The finding of fact arrived at therein was that the lady had offered herself for complete sterilisation and not for partial operation and, therefore, both her fallopian tubes should have been operated upon. It was found as a matter of fact that only the right fallopian tube was operated upon and the left fallopian tube was left untouched. She was issued a certificate that her operation was successful and she was assured that she would not conceive a child in future. It was in these circumstances, that a case of medical negligence was found and a decree for compensation in tort was held justified. The case thus proceeds on its own facts.

28. The methods of sterilisation so far known to medical science which are most popular and prevalent are not 100% safe and secure. In spite of the operation having been successfully performed and without any negligence on the part of the surgeon, the sterilised woman can become pregnant due to natural causes. Once the woman misses the menstrual cycle, it is expected of the couple to visit the doctor and seek medical advice. A reference to the provisions of the Medical Termination of Pregnancy Act, 1971 is apposite. Section 3 thereof permits termination of pregnancy by a registered medical practitioner, notwithstanding anything contained in the Penal Code, 1860 in certain circumstances and within a period of 20 weeks of the length of pregnancy. Explanation II appended to sub-section (2) of Section 3 provides:

> "*Explanation II*.—Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman."

29. And that provides, under the law, a valid and legal ground for termination of pregnancy. If the woman has suffered an unwanted pregnancy, it can be terminated and this is legal and permissible under the Medical Termination of Pregnancy Act, 1971.

30. The cause of action for claiming compensation in cases of failed sterilisation operation arises on account of negligence of the surgeon and not on account of childbirth. Failure due to natural causes would not provide any ground for claim. It is for the woman who has conceived the child to go or not to go for medical termination of pregnancy. Having gathered the knowledge of conception in spite of having undergone the sterilisation operation, if the couple opts for bearing the child, it ceases to be an unwanted child. Compensation for maintenance and upbringing of such a child cannot be claimed.

31. For the foregoing reasons, we are of the opinion that the judgments and the decrees passed by the High Court and the courts below cannot be sustained. The trial court has proceeded to pass a decree of damages in favour of the plaintiff-respondents solely on the ground that in spite of the plaintiff Respondent 2 having undergone a sterilisation operation, she became pregnant. No finding has been arrived at that will hold the operating surgeon or its employer — the State, liable for damages either in contract or in tort. The error committed by the trial court, though pointed out to the first appellate court and the High Court, has been overlooked. The appeal has, therefore, to be allowed and the judgment and decree under appeal have to be set aside…"

IN THE SUPREME COURT OF INDIA

Samira Kohli v. Dr. Prabha Manchanda
(2008) 2 SCC 1
B.N. Agrawal, P.P. Naolekar and R.V. Raveendran, JJ.

An unmarried woman aged 44 years gave her consent for diagnostic and operative laparoscopy. However, during the operation when she was unconscious, the surgeon obtained her mother's consent for hysterectomy and removed her uterus. The woman's complaint alleging negligence on part of the surgeon was rejected by the National Consumer Disputes Redressal Commission. In this appeal, the issue before the Supreme Court was whether "informed consent" of a patient is required for a surgical procedure which involves removal of reproductive organs and if so, what should be the nature of such consent. Further, it examined if and under what circumstances can consent given for a particular procedure be treated as consent for an additional surgical procedure.

Raveendran, J.: "This appeal is filed against the order dated 19-11-2003 passed by the National Consumer Disputes Redressal Commission (for short "the Commission") rejecting the appellant's complaint (OP No. 12 of 1996) under Section 21 of the Consumer Protection Act, 1986 ("the Act", for short).

UNDISPUTED FACTS

2. On 9-5-1995, the appellant, an unmarried woman, aged 44 years, visited the clinic of the first respondent (for short "the respondent") complaining of prolonged menstrual bleeding for nine days. The respondent examined and advised her to undergo an ultrasound test on the same day. After examining the report, the respondent had a discussion with the appellant and advised her to come on the next day (10-5-1995) for a laparoscopy test under general anaesthesia, for making an affirmative diagnosis.

3. Accordingly, on 10-5-1995, the appellant went to the respondent's clinic with her mother. On admission, the appellant's signatures were taken on (*i*) admission and discharge card; (*ii*) consent form for hospital admission and medical treatment; and (*iii*) consent form for surgery. The admission card showed that admission was "for diagnostic and operative laparoscopy on 10-5-1995". The consent form for surgery filled by Dr. Lata Rangan (the respondent's assistant) described the procedure to be undergone by the appellant as "diagnostic and operative laparoscopy. Laparotomy may be needed." Thereafter, the appellant was put under general anaesthesia and subjected to a laparoscopic examination. When the appellant was still unconscious, Dr. Lata Rangan, who was assisting the respondent, came out of the operation theatre and took the consent of the appellant's mother, who was waiting outside, for performing hysterectomy under general anaesthesia. Thereafter, the respondent performed an abdominal hysterectomy (removal of uterus) and bilateral salpingo-oopherectomy (removal of ovaries and fallopian tubes). The appellant left the respondent's clinic on 15-5-1995 without settling the bill.

…

5. On 19-1-1996 the appellant filed a complaint before the Commission claiming a compensation of Rs 25 lakhs from the respondent. The appellant alleged that the respondent was negligent in treating her; that the radical surgery by which her uterus, ovaries and fallopian tubes were removed without her consent, when she was under general anaesthesia for a laparoscopic test, was unlawful, unauthorised and unwarranted; that on account of the removal of her reproductive organs, she had suffered premature menopause necessitating a prolonged medical treatment and a hormone replacement therapy (HRT) course, apart from making her vulnerable to health problems by way of side-effects.

The compensation claimed was for the loss of reproductive organs and consequential loss of opportunity to become a mother, for diminished matrimonial prospects, for physical injury resulting in the loss of vital body organs and irreversible permanent damage, for pain, suffering emotional stress and trauma, and for decline in the health and increasing vulnerability to health hazards.

6. …After hearing arguments, the Commission dismissed the complaint by order dated 19-11-2003. The Commission held: (*i*) the appellant voluntarily visited the respondent's clinic for treatment and consented for diagnostic procedures and operative surgery; (*ii*) the hysterectomy and other surgical procedures were done with adequate care and caution; and (*iii*) the surgical removal of uterus, ovaries, etc. was necessitated as the appellant was found to be suffering from endometriosis (Grade IV), and if they had not been removed, there was likelihood of the lesion extending to the intestines and bladder and damaging them. Feeling aggrieved, the appellant has filed this appeal.

…

QUESTIONS FOR CONSIDERATION

17. On the contentions raised, the following questions arise for our consideration:

> (*i*) Whether informed consent of a patient is necessary for surgical procedure involving removal of reproductive organs? If so, what is the nature of such consent?
>
> (*ii*) When a patient consults a medical practitioner, whether consent given for diagnostic surgery can be construed as consent for performing additional or further surgical procedure—either as conservative treatment or as radical treatment—without the specific consent for such additional or further surgery?
>
> (*iii*) Whether there was consent by the appellant, for the abdominal hysterectomy and bilateral salpingo-oopherectomy (for short AH-BSO) performed by the respondent?
>
> (*iv*) Whether the respondent had falsely invented a case that the appellant was suffering from endometriosis to explain the unauthorised and unwarranted removal of uterus and ovaries, and whether such radical surgery was either to cover-up negligence in conducting diagnostic laparoscopy or to claim a higher fee?
>
> (*v*) Even if the appellant was suffering from endometriosis, the respondent ought to have resorted to conservative treatment/surgery instead of performing radical surgery?
>
> (*vi*) Whether the respondent is guilty of the tortious act of negligence/battery amounting to deficiency in service, and consequently liable to pay damages to the appellant?

RE: QUESTIONS (I) AND (II)

18. Consent in the context of a doctor-patient relationship, means the grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure. Consent can be implied in some circumstances from the action of the patient. For example, when a patient enters a dentist's clinic and sits in the dental chair, his consent is implied for examination, diagnosis and consultation. Except where consent can be clearly and obviously implied, there should be express consent. There is, however, a significant difference in the nature of express consent of the patient, known as "real consent" in UK and as "informed consent" in America. In UK, the elements of consent are defined with reference to the patient and a consent is considered to be valid and "real" when (*i*) the patient gives it voluntarily without any coercion; (*ii*) the patient has the capacity and competence to give consent; and (*iii*) the patient has the minimum of adequate level of information about the nature of the procedure to which he is consenting to. On the other hand, the concept of "informed consent" developed by American courts, while retaining the basic requirements of consent, shifts the emphasis on the doctor's duty to disclose the necessary information to the patient to secure his consent. …

19. In *Canterbury v. Spence* [464 F 2d 772 : 150 US App DC 263 (1972)] the United States Court of Appeals, District of Columbia Circuit, emphasised the element of doctor's duty in "informed consent" thus: (F 2d pp. 782-83, paras 11-12)

> "… It is well established that the physician must seek and secure his patient's consent before commencing an operation or other course of treatment. It is also clear that the consent, to be efficacious, must be free from imposition upon the patient. It is the settled rule that therapy not authorized by the patient may amount to a tort—a common law battery—by the physician. *And it is*

> *evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification*. Thus the physician has long borne a duty, on pain of liability for unauthorized treatment, to make adequate disclosure to the patient."
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> (emphasis supplied)

20. The basic principle in regard to patient's consent may be traced to the following classic statement by Cardozo, J. in *Schloendorff v. Society of New York Hospital* [211 NY 125 : 105 NE 92 (1914)] : (NE p. 93, paras 5-6)

> "… Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

This principle has been accepted by an English court also. F. (Mental Patient: Sterilisation), In re [(1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 sub nom *F. v. West Berkshire HA*] the House of Lords while dealing with a case of sterilisation of a mental patient reiterated the fundamental principle that every person's body is inviolate and performance of a medical operation on a person without his or her consent is unlawful…

21. The next question is whether in an action for negligence/battery for performance of an unauthorised surgical procedure, the doctor can put forth as defence the consent given for a particular operative procedure, as consent for any additional or further operative procedures performed in the interests of the patient. In *Murray v. McMurchy* [(1949) 2 DLR 442 : (1949) 1 WWR 989] the Supreme Court of British Columbia, Canada, was considering a claim for battery by a patient who underwent a caesarean section. During the course of caesarean section, the doctor found fibroid tumours in the patient's uterus. Being of the view that such tumours would be a danger in case of future pregnancy, he performed a sterilisation operation. The Court upheld the claim for damages for battery. It held that sterilisation could not be justified under the principle of necessity, as there was no immediate threat or danger to the patient's health or life and it would not have been unreasonable to postpone the operation to secure the patient's consent. The fact that the doctor found it convenient to perform the sterilisation operation without consent as the patient was already under general anaesthesia, was held to be not a valid defence. A somewhat similar view was expressed by the Court of Appeal in England in F., In re [(1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 sub nom *F. v. West Berkshire HA*] . It was held that the additional or further treatment which can be given (outside the consented procedure) should be confined to only such treatment as is necessary to meet the emergency, and as such needs to be carried out at once and before the patient is likely to be in a position to make a decision for himself. …

22. The decision in *Marshall v. Curry* [(1933) 3 DLR 260 : 60 CCC 136] decided by the Supreme Court of Nova Scotia, Canada, illustrates the exception to the rule, that an unauthorised procedure may be justified if the patient's medical condition brooks no delay and warrants immediate action without waiting for the patient to regain consciousness and take a decision for himself…Thus, the principle of necessity by which the doctor is permitted to perform further or additional procedure (unauthorised) is restricted to cases where the patient is temporarily incompetent (being unconscious), to permit the procedure delaying of which would be unreasonable because of the imminent danger to the life or health of the patient.

23. It is quite possible that had the patient been conscious, and informed about the need for the additional procedure, the patient might have agreed to it. It may be that the additional procedure is beneficial and in the interests of the patient. It may be that postponement of the additional procedure (say removal of an organ) may require another surgery, whereas removal of the affected organ during the initial diagnostic or exploratory surgery, would save the patient from the pain and cost of a second operation. Howsoever practical or convenient the reasons may be, they are not relevant. What is relevant and of importance is the inviolable nature of the patient's right in regard to his body and his right to decide whether he should undergo the particular treatment or surgery or not. Therefore at the risk of repetition, we may add that unless the unauthorised additional or further procedure is necessary in order to save the life or preserve the health of the patient and it would be unreasonable (as contrasted from being merely inconvenient) to delay the further procedure until the patient regains consciousness and takes a decision, a doctor cannot perform such procedure without the consent of the patient.

24. We may also refer to the Code of Medical Ethics laid down by the Medical Council of India (approved by the Central Government under Section 33 of the Indian Medical Council Act, 1956). It contains a chapter relating to disciplinary action which enumerates a list of responsibilities, violation of which will be professional misconduct. Clause 13 of the said chapter places the following responsibility on a doctor:

> "13. Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of a minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed."

…

26. The consent form for hospital admission and medical treatment, to which the appellant's signature was obtained by the respondent on 10-5-1995, which can safely be presumed to constitute the contract between the parties, specifically states:

> "(*A*) It is customary, except in emergency or extraordinary circumstances, that no substantial procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professional to the patient's satisfaction.
>
> (*B*) Each patient has right to consent, or to refuse consent, to any proposed procedure of therapeutic course."

27. We therefore hold that in medical law, where a surgeon is consulted by a patient, and consent of the patient is taken for diagnostic procedure/surgery, such consent cannot be considered as authorisation or permission to perform therapeutic surgery either conservative or radical (except in life-threatening or emergent situations). Similarly where the consent by the patient is for a particular operative surgery, it cannot be treated as consent for an unauthorised additional procedure involving removal of an organ, only on the ground that such removal is beneficial to the patient or is likely to prevent some danger developing in future, where there is no imminent danger to the life or health of the patient.

28. We may next consider the nature of information that is required to be furnished by a doctor to secure a valid or real consent…

29. In *Salgo v. Leland Stanford* [154 Cal App 2d 560 (1957)] it was held that a physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.

30.*Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] explored the rationale of a doctor's duty to reasonably inform a patient as to the treatment alternatives available and the risk incidental to them, as also the scope of the disclosure requirement and the physician's privileges not to disclose. It laid down the "reasonably prudent patient test" which required the doctor to disclose all material risks to a patient, to show an "informed consent". It was held: (F 2d pp. 780-82 & 786-87, paras 2-7, 10 & 20)

> "… True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.
>
> … Just as plainly, due care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve.
>
> The context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken. To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie. To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential.
>
> A reasonable revelation in these respects is not only a necessity but, as we see it, is as much a matter of the physician's duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arm's length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject. … we ourselves have found 'in the fiducial qualities of (the physician-patient) relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know'. We now find, as a part of the physician's overall obligation to the patient, a similar duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved.
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> ***

> *20*. In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked."

It was further held that a risk is material "when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy". The doctor, therefore, is required to communicate all inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the likely effect if the patient remained untreated. This stringent standard of disclosure was subjected to only two exceptions: (*i*) where there was a genuine emergency e.g. the patient was unconscious; and (*ii*) where the information would be harmful to the patient e.g. where it might cause psychological damage, or where the patient would become so emotionally distraught as to prevent a rational decision. It, however, appears that several States in USA have chosen to avoid the decision in *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] by enacting legislation which severely curtails operation of the doctrine of informed consent.

31. The stringent standards regarding disclosure laid down in *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)], as necessary to secure an informed consent of the patient, were not accepted in the English courts. In England, standard applicable is popularly known as the Bolam test, first laid down in *Bolam v. Friern Hospital Management Committee* [(1957) 1 WLR 582 : (1957) 2 All ER 118] . McNair, J., in a trial relating to negligence of a medical practitioner, while instructing the Jury, stated thus:

> (*i*) A doctor is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. … Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. (All ER p. 122 B-D)
>
> (*ii*) When a doctor dealing with a sick man strongly believed that the only hope of cure was submission to a particular therapy, he could not be criticised if, believing the danger involved in the treatment to be minimal, did not stress them to the patient.
>
> (*iii*) In order to recover damages for failure to give warning the plaintiff must show not only that the failure was negligent but also that if he had been warned he would not have consented to the treatment. (All ER p. 118 H-I)

…

33. In *Sidaway v. Board of Governors of Bethlem Royal Hospital* [1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643 (HL)] the House of Lords, per majority, adopted the Bolam test, as the measure of doctor's duty to disclose information about the potential consequences and risks of proposed medical treatment…

34. The House of Lords upheld the decision of the Court of Appeal that the doctrine of informed consent based on full disclosure of all the facts to the patient, was not the appropriate test of liability for negligence, under English law. The majority were of the view that the test of liability in respect of a doctor's duty to warn his patient of risks inherent in treatment recommended by him was the same as the test applicable to diagnosis and treatment, namely, that the doctor was required to act in accordance with the practice accepted at the time as proper by a responsible body of medical opinion…

…

Lord Bridge however made it clear that when questioned specifically by the patient about the risks involved in a particular treatment proposed, the doctor's duty is to answer truthfully and as fully as the questioner requires. He further held that remote risk of damage (referred to as risk at 1% or 2%) need not be disclosed but if the risk of damage is substantial (referred to as 10% risk), it may have to be disclosed. Lord Scarman, in minority, was inclined to adopt the more stringent test laid down in *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] .

35. In India, Bolam test has broadly been accepted as the general rule. We may refer three cases of this Court. In *Achutrao Haribhau Khodwa v. State of Maharashtra* [(1996) 2 SCC 634] this Court held: (SCC pp. 645-46, paras 14-15)

> "*14*. The skill of medical practitioners differs from doctor to doctor. The nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession and the court finds that he has attended on the patient with due care, skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence.
>
> *15*. In cases where the doctors act carelessly and in a manner which is not expected of a medical practitioner, then in such a case an action in torts would be maintainable."

36. In *Vinitha Ashok v. Lakshmi Hospital* [(2001) 8 SCC 731] this Court after referring to *Bolam* [(1957) 1 WLR 582 : (1957) 2 All ER 118] , *Sidaway* [1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643 (HL)] and *Achutrao* [(1996) 2 SCC 634] , clarified: (SCC p. 747, para 38)

> "*38*. … a doctor will be liable for negligence in respect of diagnosis and treatment in spite of a body of professional opinion approving his conduct where it has not been established to the court's satisfaction that such opinion relied on is reasonable or responsible. If it can be demonstrated that the professional opinion is not capable of withstanding the logical analysis, the court would be entitled to hold that the body of opinion is not reasonable or responsible."

37. In *Indian Medical Assn. v. V.P. Shantha* [(1995) 6 SCC 651] this Court held: (SCC p. 666, para 22)

> "*22*. … 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."

Neither *Achutrao* [(1996) 2 SCC 634] nor *Vinitha Ashok* [(2001) 8 SCC 731] referred to the American view expressed in *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)].

…

48. Having regard to the conditions obtaining in India, as also the settled and recognised practices of medical fraternity in India, we are of the view that to nurture the doctor-patient relationship on the basis of trust, the extent and nature of information required to be given by doctors should continue to be governed by the Bolam test rather than the "reasonably prudential patient" test evolved in *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] . It is for the doctor to decide, with reference to the condition of the patient, nature of illness, and the prevailing established practices, how much information regarding risks and consequences should be given to the patients, and how they should be couched, having the best interests of the patient. A doctor cannot be held negligent either in regard to diagnosis or treatment or in disclosing the risks involved in a particular surgical procedure or treatment, if the doctor has acted with normal care, in accordance with a recognised practice accepted as proper by a responsible body of medical men skilled in that particular field, even though there may be a body of opinion that takes a contrary view. Where there are more than one recognised school of established medical practice, it is not negligence for a doctor to follow any one of those practices, in preference to the others.

49. We may now summarise principles relating to consent as follows:

> (*i*) A doctor has to seek and secure the consent of the patient before commencing a "treatment" (the term "treatment" includes surgery also). The consent so obtained should be real and valid, which means that: the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what he is consenting to.
>
> (*ii*) The "adequate information" to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment or not. This means that the doctor should disclose (*a*) nature and procedure of the treatment and its purpose, benefits and effect; (*b*) alternatives if any available; (*c*) an outline of the substantial risks; and (*d*) adverse consequences of refusing treatment. But there

is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment which may persuade a patient to undergo a fanciful or unnecessary treatment. A balance should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.

(*iii*) Consent given only for a diagnostic procedure, cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment procedure. The fact that the unauthorised additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault and battery. The only exception to this rule is where the additional procedure though unauthorised, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorised procedure until patient regains consciousness and takes a decision.

(*iv*) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

(*v*) The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field. It will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment.

50. …We have, however, consciously preferred the "real consent" concept evolved in *Bolam* [(1957) 1 WLR 582 : (1957) 2 All ER 118] and *Sidaway* [1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643 (HL)] in preference to the "reasonably prudent patient test" in *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] , having regard to the ground realities in medical and health care in India. But if medical practitioners and private hospitals become more and more commercialised, and if there is a corresponding increase in the awareness of patient's rights among the public, inevitably, a day may come when we may have to move towards *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] . But not for the present.

RE: QUESTION (III)

51. "Gynaecology" (2nd Edn.) edited by Robert W. Shah, describes "real consent" with reference to gynaecologists (p. 867 et seq.) as follows:

"An increasingly important risk area for all doctors is the question of consent. No one may lay hands on another against their will without running the risk of criminal prosecution for assault and, if injury results, a civil action for damages for trespass or negligence. In the case of a doctor, consent to any physical *interference will readily be implied*; a woman must be assumed to consent to a normal physical examination if she consults a gynaecologist, in the absence of clear evidence of her refusal or restriction of such examination. The problems arise when the gynaecologist's intervention results in unfortunate side-effects or permanent interference with a function, whether or not any part of the body is removed. *For example, if the gynaecologist agrees with the patient to perform a hysterectomy and removes the ovaries without her specific consent, that will be a trespass and an act of negligence. The only available defence will be that it was necessary for the life of the patient to proceed at once to remove the ovaries because of some perceived pathology in them.*

What is meant by consent? The term 'informed consent' is often used, but there is no such concept in English Law. The consent must be real: that is to say, the patient must have been given sufficient information for her to understand the nature of the operation, its likely effects, and any complications which may arise and which the surgeon in the exercise of his duty to the patient considers she should be made aware of; only then can she reach a proper decision. But the surgeon need not warn the patient of remote risks, any more than an anaesthetist need warn the patient that a certain small number of those anaesthetised will suffer cardiac arrest or never recover consciousness. Only

> where there is a recognised risk, rather than a rare complication, is the surgeon under an obligation to warn the patient of that risk. He is not under a duty to warn the patient of the possible results of hypothetical negligent surgery….
>
> In advising an operation, therefore, the doctor must do so in the way in which a competent gynaecologist exercising reasonable skill and care in similar circumstances would have done. In doing this he will take into account the personality of the patient and the importance of the operation to her future well-being. It may be good practice not to warn a very nervous patient of any possible complications if she requires immediate surgery for, say, a malignant condition. The doctor must decide how much to say to her taking into account his assessment of her personality, the questions she asks and his view of how much she understands. If the patient asks a direct question, she must be given a truthful answer. … To take the example of hysterectomy: although the surgeon will tell the patient that it is proposed to remove her uterus and perhaps her ovaries, and describe what that will mean for her future well-being (sterility, premature menopause), she will not be warned of the possibility of damage to the ureter, vesicovaginal fistula, fatal haemorrhage or anaesthetic death."

…

56. The admission and discharge card maintained and produced by the respondent showed that the appellant was admitted "for diagnostic and (?) operative laparoscopy on 10-5-1995". The OPD card dated 9-5-1995 does not refer to endometriosis, which is also admitted by the respondent in her cross-examination. In fact, the respondent also admitted that the confirmation of diagnosis is possible only after laparoscopy test:…

57. The consent form dated 10-5-1995 signed by the appellant states that the appellant has been informed that the treatment to be undertaken is "diagnostic and operative laparoscopy. Laparotomy may be needed." The case summary dictated by the respondent and written by Dr. Lata Rangan also clearly says "admitted for hysteroscopy, diagnostic laparoscopy and operative laparoscopy on 10-5-1995". (*Note*.—Hysteroscopy is inspection of uterus by special endoscope and laparoscopy is abdominal exploration by special endoscope.)

58. In this context, we may also refer to a notice dated 5-6-1995 issued by the respondent to the appellant through counsel, demanding payment of Rs 39,325 towards the bill amount…

This also makes it clear that the appellant was not admitted for conducting hysterectomy or bilateral salpingo-oopherectomy, but only for diagnostic purposes. We may, however, refer to a wrong statement of fact made in the said notice. It states that on 10-5-1995 after conducting a laparoscopic examination, the video recording of the lesion was shown to the appellant's mother, and the respondent informed the appellant and her mother that conservative surgery would be futile and removal of uterus and more extensive surgery was preferable having regard to the more extensive lesion and destruction of the function of the tubes. But this statement cannot be true. The extensive nature of lesion and destruction of the functions obviously became evident only after diagnostic laparoscopy. But after diagnostic laparoscopy and the video recording of the lesion, there was no occasion for the respondent to inform anything to the appellant. When the laparoscopy and video recording was made, the appellant was already unconscious. Before she regained consciousness, AH-BSO was performed removing her uterus and ovaries. Therefore, the appellant could not have been informed on 10-5-1995 that conservative surgery would be futile and removal of uterus and extensive surgery was preferable in view of the extensive lesion and destruction of the function of the tubes did not arise.

59. The admission card makes it clear that the appellant was admitted only for diagnostic and operative laparoscopy. It does not refer to laparotomy. The consent form shows that the appellant gave consent only for diagnostic operative laparoscopy, and laparotomy if needed. Laparotomy is a surgical procedure to open up the abdomen or an abdominal operation…

…

63. Medical texts and authorities clearly spell out that laparotomy is at best the initial step that is necessary for performing hysterectomy or salpingo-oopherectomy. Laparotomy by itself is not hysterectomy or salpingo-oopherectomy… Laparotomy does not refer to surgical removal of any vital or reproductive organs…In medical circles, it is well recognised that a catch-all clause giving the surgeon permission to do anything necessary does not give roving authority to remove whatever he fancies may be for the good of the patient. For example, a surgeon cannot construe a consent to termination of pregnancy as a consent to sterilise the patient.

64. When the oral and documentary evidence is considered in the light of the legal position discussed above while answering Questions (*i*) and (*ii*), it is clear that there was no consent by the appellant for conducting hysterectomy and bilateral salpingo-oopherectomy.

65. The respondent next contended that the consent given by the appellant's mother for performing hysterectomy should be considered as valid consent for performing hysterectomy and salpingo-oopherectomy. The appellant was neither a minor, nor mentally challenged, nor incapacitated. When a patient is a competent adult, there is no question of someone else giving consent on her behalf. There was no medical emergency during surgery. The appellant was only temporarily unconscious, undergoing only a diagnostic procedure by way of laparoscopy. The respondent ought to have waited till the appellant regained consciousness, discussed the result of the laparoscopic examination and then taken her consent for the removal of her uterus and ovaries. In the absence of an emergency and as the matter was still at the stage of diagnosis, the question of taking her mother's consent for radical surgery did not arise. Therefore, such consent by mother cannot be treated as valid or real consent. Further a consent for hysterectomy, is not a consent for bilateral salpingo-oopherectomy.

…

68. We find that the Commission has, without any legal basis, concluded that "the informed choice has to be left to the operating surgeon depending on his/her discretion, after assessing the damage to the internal organs, but subject to his/her exercising care and caution". It also erred in construing the words "such medical treatment as is considered necessary for me for…" in the consent form as including surgical treatment by way of removal of uterus and ovaries.

69. The Commission has also observed: "whether the uterus should have been removed or not or some other surgical procedure should have been followed are matters to be left to the discretion of the performing surgeon, as long as the surgeon does the work with adequate care and caution". This proceeds on the erroneous assumption that where the surgeon has shown adequate care and caution in performing the surgery, the consent of the patient for removal of an organ is unnecessary. The Commission failed to notice that the question was not about the correctness of the decision to remove the uterus and ovaries, but the failure to obtain the consent for removal of those important organs. There was also a faint attempt on the part of the respondent's counsel to contend that what were removed were not "vital" organs and having regard to the advanced age of the appellant, as procreation was not possible, uterus and ovaries were virtually redundant organs…Suffice it to say that for a woman who has not married and not yet reached menopause, the reproductive organs are certainly important organs. There is also no dispute that removal of ovaries leads to abrupt menopause causing hormonal imbalance and consequential adverse effects.

RE: QUESTIONS (IV) AND (V)

…

74. The evidence therefore demonstrates that on laparoscopic examination, the respondent was satisfied that the appellant was suffering from endometriosis. The evidence also demonstrates that there is more than one way of treating endometriosis. While one view favours conservative treatment with hysterectomy as a last resort, the other favours hysterectomy as a complete and immediate cure. The age of the patient, the stage of endometriosis among others will be determining factors for choosing the method of treatment. The very suggestion made by the appellant's counsel to the expert witness Dr. Sudha Salhan that worldwide studies show that most hysterectomies are conducted unnecessarily by gynaecologists, which demonstrates that it is considered as a favoured treatment procedure among medical fraternity, offering a permanent cure. Therefore the respondent cannot be held to be negligent, merely because she chose to perform radical surgery in preference to conservative treatment. This finding however has no bearing on the issue of consent which has been held against the respondent. The correctness or appropriateness of the treatment procedure, does not make the treatment legal, in the absence of consent for the treatment.

…

RE: QUESTION (VI)

76. In view of our finding that there was no consent by the appellant for performing hysterectomy and salpingo-oopherectomy, performance of such surgery was an unauthorised invasion and interference with the appellant's body which amounted to a tortious act of assault and battery and therefore a deficiency in service. But as noticed above, there are several mitigating circumstances. The respondent did it in the interest of the appellant. As the appellant was already 44 years' old and was having serious menstrual problems, the respondent thought that by surgical removal of

uterus and ovaries she was providing permanent relief. It is also possible that the respondent thought that the appellant may approve the additional surgical procedure when she regained consciousness and the consent by the appellant's mother gave her authority. This is a case of the respondent acting in excess of consent but in good faith and for the benefit of the appellant. Though the appellant has alleged that she had to undergo hormone therapy, no other serious repercussions is made out as a result of the removal. The appellant was already fast approaching the age of menopause and in all probability required such hormone therapy. Even assuming that AH-BSO surgery was not immediately required, there was a reasonable certainty that she would have ultimately required the said treatment for a complete cure. On the facts and circumstances, we consider that interests of justice would be served if the respondent is denied the entire fee charged for the surgery and in addition, directed to pay Rs 25,000 as compensation for the unauthorised AH-BSO surgery to the appellant.

77. We accordingly allow this appeal and set aside the order of the Commission and allow the appellant's claim in part…"

IN THE SUPREME COURT OF INDIA

Martin F. D'Souza v. Mohd. Ishfaq
(2009) 3 SCC 1
Markandey Katju and R.M. Lodha, JJ.

In this appeal against a decision of the National Consumer Disputes Redressal Commission, the Supreme Court discussed the general principles of medical negligence and their application to particular cases. While doing so, the Court confirmed that the earlier position in State of Haryana v. Santra ((2000) 5 SCC 182) as per which a doctor was held liable in case of child birth following sterilization, stands overruled by the decisions in State of Punjab v. Shiv Ram ((2005) 7 SCC 1) and State of Haryana v. Raj Rani ((2005) 7 SCC 22).

Katju, J.: "…

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

…

Application of the abovementioned general principles to particular cases

Decisions of the Courts

…

53. In *State of Haryana v. Raj Rani* [(2005) 7 SCC 22] it was held that if a child is born to a woman even after she had undergone a sterilisation operation by a surgeon, the doctor was not liable because there cannot be a 100% certainty that no child will be born after a sterilisation operation. The Court followed the earlier view of another three-Judge Bench in *State of Punjab v. Shiv Ram* [(2005) 7 SCC 1] . These decisions will be deemed to have overruled the two-Judge Bench decision in *State of Haryana v. Santra* [(2000) 5 SCC 182 : AIR 2000 SC 1888] in which it was held that if a child is born after the sterilisation operation the surgeon will be liable for negligence…"

IN THE HIGH COURT OF DELHI

Dr. R.R. Rana v. State
2012 SCC OnLine Del 3187
Pratibha Rani, J.

The complainant's wife had approached the petitioner for medical termination of pregnancy (MTP). As her pregnancy continued even after the procedure was conducted, she approached the petitioner again. The petitioner performed another operation for MTP during which a hole was made in her uterus along with a cut in her intestine. An FIR was registered and the petitioner was charged under Sections 420 and 338 of the Indian Penal Code, 1860. In this revision petition challenging the Magistrate's order framing the charges, the High Court examined whether the petitioner was prima facie liable for falsely representing conduct of first procedure for MTP and causing grievous injury due to negligence in conduct of second procedure for MTP.

Rani, J.: "1. By this revision petition filed under Section 397 read with Section 401 Cr.P.C. the petitioner is impugning the order dated 14.09.2005 whereby the learned M.M ordered to frame charge against the petitioner Dr. R.R. Rana (accused in case FIR No. 48/2000, under Sections 338/420 IPC, registered at P.S. Seema Puri, Delhi) for committing the offence punishable under Section 338/420 IPC.

2. In brief the case of the prosecution is that Smt. Kusum Pahwa, wife of the complainant Manmohan Pahwa was pregnant and she along with her husband contacted the petitioner for medical termination of pregnancy (MTP). On 07.01.1997 the wife of the complainant visited the clinic of the petitioner to get the pregnancy terminated in his clinic i.e. Munpee Clinic and Fertility Centre. After keeping the wife of the complainant in the clinic for a few hours, the petitioner informed the complainant and his wife that the MTP has been done. He charged Rs. 1,500/- and discharged the patient Smt. Kusum Pahwa.

3. After discharge from the clinic, since certain complications developed, the complainant got the ultrasound test of his wife conducted at Bhupender Clinic, Bulandshahr (U.P.) on 03.02.1997 and the ultrasound report confirmed pregnancy of 13 weeks.

4. It is also the prosecution case that the complainant again contacted the petitioner on 05.02.1997 and confronted him with the ultrasound report. On this, Dr. R.R. Rana, the petitioner admitted his mistake and offered to conduct the case at Rajdhani Nursing Home, A-5, Jagatpuri, Shahdara, Delhi on 06.02.1997. The complainant along with his wife reached Rajdhani Nursing Home where his wife was admitted and operated…In the evening when his wife regained consciousness, she was in acute pain. The complainant consulted his brother Dr. Baldev Pahwa about the condition of his wife and his brother also talked to the petitioner in this regard. The patient was discharged on 10.02.1997, but the condition of the patient continued deteriorating. Dr. Rana was also made to pay home visit and he left after giving an injection. When the condition of the wife of the complainant became very serious she was removed to GTB Hospital where the Doctors informed that during operation a hole has been made in the uterus and a cut has been made in the intestine through which the stool passes off the body. Wife of the complainant was again operated in GTB Hospital and remained hospitalized for a long time and suffered from many complications.

5. The complainant also expressed suspicion on the genuineness of the degree of MBBS and MS in Obstetrics and Gynaecology and qualifications of Dr. R.R. Rana, petitioner and prayed for legal action against him. On the basis of complaint and medical record, FIR was registered against the petitioner for committing the offences punishable under Sections 420/120-B/338 IPC…

6. After hearing arguments and discussing relevant case law on the point of charge, the learned M.M, vide the impugned order dated 14.09.2005, formed an opinion that prima facie a case for committing the offences punishable under Sections 420/338 IPC is made against the accused and charged him for the said offences.

…

11. The legal position is almost settled that at the stage of charge, the Court is not required to consider pros and cons of the case. The Court can only sift and weigh the material for the limited purpose of finding whether or not a prima facie case for framing the charge has been made out. In my opinion, the learned M.M has taken into account all the relevant material and passed the order impugned herein following the parameters laid down in various judgments referred to by him in the said order.

…

13. In the instant case from the statement of the complainant as well as prescription slip of Munpee Clinic which is printed on the letter head of the petitioner, prima facie it is revealed that on 07.01.1997 by falsely representing to the complainant that medical termination of pregnancy has been done, he induced the complainant to part with Rs. 1,500/-…This prima facie makes the petitioner liable to be charged for commission of the offence punishable under Section 420 IPC.

14. Another contention of the petitioner that at the time of admission in GTB hospital, wife of the complainant did not mention about the first MTP or there was only one MTP conducted about 5-6 days back, does not cut much ice for the reason the complainant knew that MTP had been done only 5-6 days back at Rajdhani Nursing Home and prior to that he had been cheated by the petitioner by falsely misrepresenting that the MTP had been done.

15. Now the question arises whether for making a hole in the uterus and making a cut in the intestine through which the stool passes off the body, the petitioner can be charged for commission of offence punishable under Section 338 IPC.

16. The decision of *Indian Medical Association v. V.S. Shantha* (1995) 6 SCC 651 has adopted Bolam test as guidelines for the Courts to adjudicate the medical negligence. In *Jacob Mathew v. State of Punjab* (2005) SCC (Crl.) 1369, the legal principles laid down in *Dr. Suresh Gupta v. Govt. of NCT of Delhi* (2004) 6 SCC 422 were re-affirmed by the Supreme Court. While summing up the conclusion, it was held as under:-

> "(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, which 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.
>
> (4) The test for determining medical negligence as laid down in Bolam's case [1957] 1 W.L.R. 582, 586 holds good in its applicability in India."

17. In the instant case, the nature of injuries suffered by the wife of the complainant have been described as major which can be termed as grievous. While treating a patient for medical termination of pregnancy, the nature of injuries which the wife of complainant allegedly suffered at the hands of the petitioner are such that no professional or skilled person in his ordinary senses and prudence could have caused. It appears that the petitioner did not have even the ordinary skill to perform the MTP.

18. *Prima facie*, taking into consideration the material adduced by the prosecution against the petitioner which is to be proved during trial, I am of the considered view that while ordering for framing of charge against the petitioner for committing offences punishable under Sections 420/338 IPC, no illegality or infirmity has been committed by the learned M.M. The impugned order requires no interference by this Court.

19. The revision petition is hereby dismissed with no order as to costs..."

IN THE HIGH COURT OF MADRAS

S. Mary v. Union of India
(2013) 2 CTC 332
N. Paul Vasanthakumar, J.

Due to non-availability of hospital beds, the petitioner's caesarean operation was delayed. As a result, her uterus was severely damaged and had to be removed, and she suffered a stillbirth. In this writ petition, the High Court examined whether the respondents were negligent in not extending timely treatment to the petitioner and whether shortage of resources can be a ground to deny her compensation.

Vasanthakumar, J.: "**1.** This Writ Petition is filed with a prayer to issue a Writ of Mandamus directing the Respondents to consider Petitioner's Representations dated 1.7.2011, 18.7.2011 & 14.11.2011 and consequently direct the Respondents 1 & 2 to pay compensation of Rs. 10 lakhs to the Petitioner for the negligent acts done by the staffs and Doctors in the Government Hospitals in Tamil Nadu and Pondicherry/4th to 7th Respondents herein.

2. The brief facts necessary for disposal of the Writ Petition are as follows:

…

(b) Petitioner became pregnant for the second time and after full term, on 19.6.2010 her husband took the Petitioner to the Government Headquarters Hospital at Kallakurichi and admitted her as an inpatient. The Hospital Authorities informed the Petitioner that operation time in the hospital was only between 7 a.m. and 12 noon and as the Petitioner was already suffering from Labour pain, she was directed to approach the Hospital at Salem or at Pondicherry.

(c) On the way to Pondicherry, due to severe pain, Petitioner's husband took her to the Government Medical College Hospital, Mundiyambakkam, Villupuram, and according to the Petitioner, the authorities in the said Hospital, after consulting the Doctors, refused to admit the Petitioner and directed her to approach JIPMER Hospital at Pondicherry.

(d) Thereafter, Petitioner's husband took the Petitioner to JIPMER Hospital at Pondicherry and admitted her at 12.00 mid night on 19.6.2010/20.6.2010. As the Petitioner was suffering from labour pain from 4.00 p.m. on 19.6.2010 onwards, the Doctors in the JIPMER Hospital took a decision to conduct emergent caesarean at 3.00 a.m. on 20.6.2010, *i.e.*, within three hours of her admission in the hospital and directed the staff members in the hospital to shift the Petitioner to Ward No. 17 for initial preparation for conducting caesarean.

(e) The staff of the hospital, in a negligent manner shifted the Petitioner Ward No. 12, which is a normal ward. Doctors also failed to note the mistake committed by the staff and failed to do caesarean at 3.00 a.m. on 20.6.2010. Petitioner's husband was not allowed to be in the maternity ward as several patients expecting delivery were admitted.

(f) According to the Petitioner, the staff nurse noted discharge of blood and she was taken to the operation theatre at 9.30 a.m. on 20.6.2010 and noted that her uterus was fully damaged and a male child was also found dead. Finally the Doctors removed Petitioner's uterus, according to the Petitioner, without the consent of Petitioner's husband. Petitioner was immediately admitted in ICU ward and was given three units of blood and four units of plasma. On 21.6.2010 the Doctors informed the Petitioner that a male child was born and died in Neonatal Intensive Care Unit (NICU).

…

(h) Petitioner having lost her male child, uterus and health and suffering from continuous abdominal pain, she is unable to do any work and living with her husband and a female child. As her husband is already suffering from spinal cord problem, there is no income to Petitioner's family and according to the Petitioner, due to the negligent act of Doctors and staff members of the 4th Respondent-Hospital, Petitioner is put to such a predicament for which the 4th Respondent is bound to pay compensation.

…

…

7. The point for consideration in this Writ Petition is as to whether the Petitioner was put to suffering and she lost her male child and uterus due to non-extending of timely treatment in the 4th Respondent-Hospital.

…

10. …[I]t is an admitted position that even though caesarean time was fixed at 3.00 a.m. on 20.6.2010, actually caesarean was conducted only at 9.20 a.m. on 20.6.2010, which according to the 4th Respondent was due to non-availability of operation theatre. The staff of the hospital and Doctors in the hospital cannot be blamed personally for not conducting caesarean to the Petitioner at 3.00 a.m. on 20.6.2010 as it is pleaded in the Counter Affidavit that the Petitioner was shifted to Ward No. 12, which is a normal ward, where pregnant patients, post operative patients were kept for treatment. Petitioner's uterus was also beyond repair at the time of conducting caesarean, that was at 9.20 a.m. on 20.6.2010 and blood loss was severe. Therefore the Doctors decided to perform hysterectomy to save the Petitioner's life and for doing such hysterectomy, consent from the Petitioner's husband, who was waiting outside the operation theatre was obtained as per the Counter Affidavit filed. Even otherwise, Petitioner's husband has given a consent to that effect in writing to do all kinds of treatment and a Consent Letter signed by Petitioner's husband is filed before this Court as stated supra. Petitioner was thereafter given treatment in the Intensive Care Unit and subsequently she was discharged on 1.7.2010. Thus, it is evident that due to non-availability of operation theatre/table, even though caesarean was to be performed at 3.00 a.m. on 20.6.2010, the Doctors could perform caesarean only at 9.20 a.m., which resulted in asphyxia to the child in the womb and also damaged the uterus of the p Petitioner.

…

12. It is not the case of the 4th Respondent-Hospital that the child was not alive when Doctors examined the Petitioner at 00.39 hours on 20.6.2010. It is also not the case of the 4th Respondent that the child could have died before 3.00 a.m., that was prior to the time fixed for conducting caesarean, as such death of the child was due to asphyxia, which in turn was due to the delay in conducting caesarean at 3.00 a.m. and taking out the child from the uterus of the Petitioner only at 9.30 a.m.

13. Article 21 of the Constitution of India guarantees fundamental right to live to every citizen.

(a) The right of a citizen to preserve one's life and get medical treatment on time was considered by the Supreme Court in the decision reported in *P.T. Parmanand Katara v. Union of India*, 1989 (4) SCC 286 : AIR 1989 SC 2039, wherein in paragraph 8 it is held thus,—

> "*8*. Article 21 of the Constitution casts the obligation on the State to preserve life. The provision as explained by this Court in scores of decisions has emphasised and reiterated with gradually increasing emphasis that position. A Doctor at the Government Hospital positioned to meet this State obligation is, therefore, duty bound to extend medical assistance for preserving life. Every Doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life. No law or State action can intervene to avoid/ delay the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way."

(b) In *Chameli Singh v. State of U.P.*, 1996 (2) SCC 549 : AIR 1996 SC 1051, in paragraph 8 the Hon'ble Supreme Court held thus—

> "*8*. In any organised society, right to live as a human being is not ensured by meeting only the animal needs of man. It is secured only when he is assured of all facilities to develop himself and is freed from restrictions which inhibit his growth. All human rights are designed to achieve this object. Right to live guaranteed in any civilised society implies the right to food, water, decent environment, education, medical care and shelter. These are basic human rights known to any civilised society. All Civil, political, social and cultural rights enshrined in the Universal Declaration of Human Rights and Convention or under the Constitution of India cannot be exercised without these basic human rights."

(c) In *Paschim Bangal Khet Mazdoor Samity v. State of West Bengal*, 1996 (4) SCC 37 : AIR 1996 SC 2426 : 1997 (1) MLJ 7, the Hon'ble Supreme Court held that the patient cannot be denied emergency aid due to non-availability of bed in the Government Hospital and if any such denial is made, the same amounts to denial of right to life guaranteed under Article 21 of the Constitution of India.

(d) The Division Bench of Orissa High Court in the case in OJC No. 8819 of 2000 order dated 17.9.2012, considered the medical negligence for not giving timely treatment due to which a lady and child died. The Division Bench ordered Rs. 5 lakhs as compensation with 6% interest till date of payment.

(e) The Calcutta High Court in the decision reported in *Ranjit Kumar Das v. Medical Officer, ESI Hospital*, 1997 (3) CPJ 336 (CDRC West Bengal) held that even the failure of the hospital to treat the card-holder on the ground of absence of bed would amount to negligence and therefore, adequate compensation must be provided.

14. From the above cited decisions it is beyond doubt that the action of the 4th Respondent in not conducting caesarean at 3.00 a.m. on 20.6.2010 due to want of table in the operation theatre is not a ground to deny compensation claimed by the Petitioner, particularly when it is proved that the child was alive till the time fixed for operation, *i.e.*, 12.00 midnight on 19.6.2010 and beyond 3.00 a.m. on 20.6.2010.

15. The 4th Respondent is also not justified in blaming the Respondents 2, 3, 5 to 7 for not extending treatment to the Petitioner in the hospital at Kallakuruchi or in the Government Medical College Hospital, Villupuram, as the Petitioner's husband willingly taken the Petitioner to admit her in the 4th Respondent-Hospital, which is as per the wish of the Petitioner as well as her husband. However, the action of the Doctors and staff in the Government Headquarters Hospital at Kallakuruchi and in the Government Medical College Hospital at Villupuram in not providing treatment to the Petitioner is contrary to the Code of Medical Ethics drawn up with the approval of the Central Government under Section 33 of the Indian Medical Council Act, 1956, which states that every Doctor, whether at the Government Hospital or otherwise, has professional obligation to extend his services to protect the life. This obligation being total, absolute and paramount, laws or procedures, whether in statute or otherwise cannot be sustained and, therefore must give way.

16. The Government is spending huge money for promotion of health. However in this case it is proved that adequate operation theatre/table is not provided in the well reputed hospital *i.e.*, JIPMER hospital, Pondicherry, which resulted in the death of a male child and caused physical and mental agony to the Petitioner and her family. As right to health is recognised as a fundamental right, not providing adequate table to conduct caesarean in the Government Hospital, either due to inadequacy of space or funds, cannot be a ground. Hence, the Petitioner is to be compensated by the 4th Respondent.

17. The next issue to be considered is how much amount can be ordered to be paid by the 4th Respondent as compensation to the Petitioner, who not only lost her child but also lost her uterus. Petitioner, having lost a fully grown child at the time of conducting caesarean belatedly and lost her uterus permanently, is entitled to get adequate compensation.

18. There is no codified law for arriving at the quantum of compensation in cases of this type. The enactments like Motor Vehicles Act, 1988; Workmen's Compensation Act, 1948; and Fatal Accidents Act, 1855 may be applied for arriving at just compensation.

19. Considering the facts and circumstances of the case, I am of the view that interest of justice would be met by directing the 4th Respondent to pay a sum of Rs. 2.00 lakhs for the loss/death of child of the Petitioner due to the delay in conducting caesarean, and Rs. 1.00 lakh for the loss of uterus due to the delay in performing caesarean and Rs. 25,000/- for pain and sufferings. The said compensation amounts totalling Rs. 3.25 lakhs is directed to be paid by the 4th Respondent to the Petitioner within a period of four weeks from the date of receipt of copy of this order…"

IN THE HIGH COURT OF DELHI

Nirmala Devi & Ors. v. Union of India
AIR 2015 (NOC 224) 92
Vibhu Bakhru, J.

On account of a failed sterilization procedure, petitioners no. 1 and 2 begot a child who was diagnosed with a mental disorder. In this writ petition filed by the parents and the child, the petitioners sought compensation for their child's education, livelihood and development, and medical negligence resulting in failure of sterilization. The High Court examined whether the "right to live with dignity" under Article 21 could be invoked to provide resources for upbringing the petitioners' child.

Bakhru, J.: "1. Petitioner Nos. 1 and 2 are parents of petitioner no. 3, Master Deependra, who was born on 14.06.2001. Master Deependra is stated to be suffering from mental disorder and requires constant care...The petitioners claim that they have a right to life under Article 21 of the Constitution of India and have prayed that the respondents make suitable arrangements for the livelihood, education and development of their son…In addition, petitioner nos. 1 and 2 have claimed compensation of Rs. 50 lacs for the indignation and humiliation faced by them on account of failed sterilisation procedure performed on petitioner No. 1.

…

3. I have heard the learned counsel for the petitioners at length. Although, the petitioner nos. 1 and 2 have alleged that the attending surgeons/medical staff were negligent and have prayed that the respondents be held liable to compensate the petitioners for the failure of sterilization procedure conducted on petitioner no. 1, however, the grievance of the petitioner as one understands from the arguments that were advanced is not that the petitioners are aggrieved on account of any medical negligence but are distressed on account of the problems faced by them in bringing up a child with a mental disorder.

4. The Supreme Court in the case of *Jacob Mathew v. State of Punjab*: (2005) 6 SCC 1 approved the tests as laid down in the case of *Bolam v. Friern Hospital Management Committee*: (1957) 2 AII ER 118 (QBD) with respect to medical negligence…

5. In *State of Punjab v. Shiv Ram*: (2005) 7 SCC 1, the Supreme Court following the decision in *Jacob Mathew* (supra) held as under:-

> "We are, therefore, clearly of the opinion that merely because a woman having undergone a sterilisation operation became pregnant and delivered a child, the operating surgeon or his employer cannot be held liable for compensation on account of unwanted pregnancy or unwanted child. The claim in tort can be sustained only if there was negligence on the part of the surgeon in performing the surgery. The proof of negligence shall have to satisfy Bolam's test. So also, the surgeon cannot be held liable in contract unless the plaintiff alleges and proves that the surgeon had assured 100% exclusion of pregnancy after the surgery and was only on the basis of such assurance that the plaintiff was persuaded to undergo surgery. As noted in various decisions which we have referred to hereinabove, ordinarily a surgeon does not offer such guarantee."

6. In the present case also, the fact that the sterilisation procedure had failed, does not necessarily indicate that the surgeons/medical practitioners attending petitioner No. 1 were professionally negligent and thus no compensation can be granted to the petitioners in this proceeding. In my view, no compensation for failure of the sterilisation procedure can be awarded also for the reason that the claim is highly belated and has been preferred after a period of 13 years. It is also pertinent to note that the petitioner No. 1 could have terminated the unwanted pregnancy but petitioner Nos. 1 and 2 decided to proceed with the same, which resulted in the birth of petitioner No. 3.

7….While the Court may empathise with the condition of petitioner nos. 1 and 2, there is no judicial principal (sic) which could be adopted to award any compensation to the petitioners on account of bringing up a challenged child.

8. In my view, the reference to Article 21 of the Constitution of India is not apposite in the facts of the present case. While, it is correct that the Supreme Court of India over a period of time has liberally interpreted the words "life and liberty" and Article 21 of the Constitution of India has been read to include "right to live with dignity". However, the same is not applicable in the present case and cannot be extended to assist the petitioners in travails of their life. It is pertinent to note that the focus of the petitioners' arguments was not to seek medical assistance or access to hospital but resources

for the care and development of petitioner No. 3. Undoubtedly, the state must endeavour to provide social security to its citizens, but given the constrains of resources a mandamus to provide the same cannot be issued. The reference of learned counsel for the petitioners to Article 15(3) and Article 21A of the Constitution of India is also misplaced.

9. For the reasons stated above, this Court cannot grant relief to the petitioners. The writ petition is dismissed."

IN THE HIGH COURT OF MADRAS

Sumathi v. Dr. Suganthi
(2014) 3 MWN (Civil) 785
R. Mahadevan, J.

The appellant/plaintiff preferred this second appeal as an indigent person challenging the orders passed by the lower courts dismissing her claim for compensation for failed sterilization and birth of an unintended child. The High Court examined the legality of shifting the burden of proving medical negligence onto the plaintiff by the lower courts.

Mahadevan, J.: "…

2. …The case of the plaintiff is as follows:—

> The plaintiff, being mother of two children, had underwent sterilization operation on 10.3.1990 which was done by the first defendant, the then Medical Officer in the Government Hospital, Tiruchengode. But, thereafter, to her surprise, she became pregnant and on 22.11.1991, she gave birth to a male child in Government Hospital, Tiruchengode. According to the plaintiff, the pregnancy was due to surgical failure due to deliberate negligency and wanton carelessness on the part of the first defendant and hence, she claimed a total sum of Rs. 1,00,000/= as damages.

…

5. The second appeal has been admitted identifying the following question to be the substantial question of law involved in the second appeal:

> i) Whether the shifting of the burden of proof on the plaintiff that there is medical negligence on the part of the Doctor who performed the surgery, can be legally sustained and if not, does not vitiate the judgments in challenge?

…

7. The suit is one for the relief of damages for the alleged medical negligence on the part of the first defendant, a Doctor in the Government Hospital, Tiruchengode while conducting sterilization on the plaintiff. It is not in dispute that the plaintiff, having blessed with two children, had underwent sterilization surgery with the intention of avoiding further pregnancy due to her family circumstances and her status. The plaintiff is from a remote village. It is contended that she belongs to a poor family and her husband is a driver by profession. The plaintiff is said to have given birth to all the three children only in Government Hospital instead of approaching private hospitals which strengthens her contention that she is from weaker section of the society. The trend in the village, one can see, is that people will not come on their own volition to undergo a sterilization even after giving birth to a number of children. They deem it as a sin and pregnancy should not be avoided as it is blessed by Almighty. Only on wide publicity by the Government and the education offered to the folk people, nowadays, they come forward to venture it. It is an appreciable maturity level in the society from that of fearing even for a vaccination. Birth control has the topmost priority in our nation for its move in the path of development. Therefore, people who want to join in such a move should be encouraged. Such being the situation, a lady with a poor family status is burdened with one more child even after the sterilization.

8. It is relevant to see that in *Keith Allenby v. H.* ((2013) 2 SCC 1), it has been held as under:

> "53. If, however, the purpose of the medical treatment is to prevent pregnancy from occurring and by reason of medical error that purpose is not achieved, it does not seem to us that, just because the pregnancy then occurs as a biological process, there should be no cover for the consequences. The development of the foetus following impregnation occurs because of the medical error, just as in

the case of the undetected tumour. It causes significant physical changes to the woman's anatomy, which of course occur naturally but still cause discomfort and, at least ultimately, pain and suffering. If a disease or infection consequential on medical misadventure can be classified by the statute as a personal injury, it does not involve any greater stretching of language to similarly include a pregnancy which has the same cause. We should add that it can make no difference that the direct cause of the pregnancy is an act of sexual intercourse which occurs separately from the negligently performed operation. The pregnancy is still caused by the surgeon's negligence, and would not have happened without that negligence. It is the same in a case of negligent treatment by a health professional falling under s 32(6), where the transmission of the infection occurs separately from the failure to properly treat the patient who passes on the infection, and is directly caused by the proximity of the patient and the person to whom the infection is passed. Another example would be where a medical practitioner negligently carries out a vaccination procedure sought by a patient who later catches from a third person the very disease against which he or she wished to be protected.

.....

60. The next question, and it is a key question in the case, is whether the resulting pregnancy amounts to "personal injury" under and for the purposes of the legislation. That expression is defined to mean "physical injuries… including, for example, a strain or a sprain". The question whether a woman who becomes pregnant as a result of a failed sterilisation operation thereby suffers physical injuries is the same question as that which arises if a pregnancy is the result of rape. The answer must logically be the same in respect of both causes. The fact that one results from medical misadventure and the other from accident cannot make any difference.

61. I am unable to accept that the changes which occur to a woman's body as a result of pregnancy do not come within the compass of the expression "physical injuries" in the context of the legislation in issue. Clearly the bodily changes are of a physical kind. The only issue is whether they represent an injury or injuries for the purposes of the Act. I consider they do. In both cases (rape and failed sterilisation) the bodily changes which ensue qualify as personal injury. They are apt to cause a substantial degree of physical discomfort and, quite often, substantial pain and suffering. The changes produce bodily sensations which are of much greater consequence and duration than the examples given of a strain or a sprain.

62. I am not persuaded to a different view by the argument that pregnancy is "a natural process" and is necessary for the survival of the human species. A woman is entitled to choose whether or not to become pregnant. If she does not wish to do so, the consequences of her becoming pregnant are not to be discounted because pregnancy per se is a natural process. A woman who takes steps to avoid a natural consequence of sexual intercourse ought to be regarded as suffering physical injury when those natural consequences follow as a result of medical misadventure. In the same way, a woman who is raped, and becomes pregnant as a result, thereby suffers physical injury caused by the accident of sexual assault. This reasoning does not lead to all unwanted pregnancies being covered by the Act. In order to attract cover the pregnancy must be caused either, as here, by medical misadventure, or by rape.

…

80. Medical misadventure arises out of medical error or medical mishap. 17 Medical mishap (an adverse consequence of treatment 18) is not in issue here. Rather, it is said that the failed sterilisation resulted from medical error. Medical error does not exist "solely because desired results are not achieved", but must amount to "the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances". 19 Whether the failure in the sterilisation undertaken was because the appellant did not observe the standard of care and skill reasonably to be expected is not conceded or established. It is however assumed for the purposes of the strike out determination that the pregnancy was the result of such medical error."

9. In the case of *Mrs. Vijaya v. The Commissioner, Corporation Of Chennai* (2004-3-LW 201) this court has held as under:—

> "7. The decision reported in the case of *State of Haryana v. Santra* ((2000) 5 SCC 182 : 2001-2-LW 58), is more appropriate in the sense that it relates to a case of birth of a child in spite of tubectomy operation. The Supreme Court held that there was negligence on the part of the Doctors and ultimately, the State Government was responsible for the negligence. The award of compensation by the Court below was upheld by the Supreme Court. Ultimately, it was observed:—
>
> [...]
>
> .....
>
> "42. Having regard to the above discussion, we are positively of the view that in a country where the population is increasing by the tick of every second on the clock and the Government had taken up family planning as an important programme for the implementation of which it has created mass awakening for the use of various devices including sterilisation operation, the doctor as also the State must be held responsible in damages if the sterilisation operation performed by him is a failure on account of his negligence, which is directly responsible for another birth in the family, creating additional economic burden on the person who had chosen to be operated upon for sterilisation."
>
> 8. Applying the ratio of the above said decision, it has to be seen whether the petitioner is entitled for any compensation. The main objection raised by the learned counsel for the respondents is to the effect that there is no material on record to establish negligence on the part of the Doctors and in normal course, there can be failure of such operation. It is, of course true that the petitioner has not produced any positive material to show negligence at the time of operation. However, in such case, where the failure rate is negligible, the initial presumption would be regarding the negligence in the operation. Thus, the doctrine of Res ipsa loquitur would be applicable to such cases. In other words, where it is found that in spite of undergoing sterilising operation, there is conception and birth of child, the burden would be shifted to the concerned Doctor, to prove that there was no negligence and the fact that "there was conception in spite of tubectomy operation" would speak for itself. In the present case, except a vague denial about the allegations and shifting the blame to the petitioner, no material has been produced on behalf of the respondents to prove that due care had been taken at the time of operation."

10. ...The courts below have rejected the case of the plaintiff that her pregnancy was only due to medical negligence on the part of the first defendant mainly on the ground that the plaintiff failed to prove the medical negligence. The courts below have, unreasonably expected the plaintiff, a poor folk lady, to prove the medical negligence. In *Savita Garg v. National Heart Institute* ((2004) 8 SCC 56), a Division Bench of the Hon'ble Supreme Court has held that once a claim petition is filed and the complainant has successfully discharged the initial burden that the Hospital/Clinic/Dctor was negligent, and that as a result of such negligence the patient died, then in that case the burden lies on the hospital and the doctor concerned who treated the patient to show that there was no negligence involved in the treatment.

11. In a similar case in *Dr. Alice George v. Lakshmi* (2007 (1) CTC 496), the plaintiff therein underwent the family planning operation in the year 1987, but, gave birth to another child in the year 1990 and claimed damages. The defence of the Medical Officer therein was that even after the sterilization operation, there was approximately 0.5% of pregnancy. The courts below awarded damages and the second appeal preferred by the Medical Officer was dismissed by this court by holding that it is for the medical person to prove that the operation was done carefully and without any negligence whatsoever.

12. The learned counsel for respondents 2 and 3, by pointing out the decision of a Full Bench of the Honourable Supreme Court in *State of Punjab v. Shiv Ram* (CDJ 2005 SC 616), submitted that the Honourable Supreme Court, while allowing an appeal filed by the State against the decree for damages passed by the courts below in a case of alleged medical negligence due to failure of sterilization operation, has clarified the position with regard to claims regarding failure of sterilization and following the decision of the Honourable Apex Court, the claim of the plaintiff has to be rejected.

13. Of course, the Full Bench of the Honourable Apex Court has held in the above cited decision that the cause of action for claiming compensation in cases of failed sterilization operation arises on account of negligence of the surgeon and not on account of childbirth; that failure due to natural causes would not provide any ground for claim; that it is for the woman who has conceived the child to go or not to go for medical termination of pregnancy and having gathered the knowledge of conception in spite of having undergone sterilization operation, if the couple opts for bearing the child, it ceases to be an unwanted child and compensation for maintenance and upbringing of such a child cannot be claimed.

14. It is also relevant to note that in the above decision, the Full Bench had discussed the post female sterilization pregnancy with the aid of articles from the medical journals and listed out the causes for such failure and pointed out the finding of US study that 1 of every 3 pregnancies after sterilization was ectopic…

15. In the above case, the childbirth was after seven years from the date of sterilization operation conducted on the victim lady. But, in the present case, the pregnancy itself took within a year after sterilization operation and the plaintiff gave birth to a child after 19-1/2 months. The rate of risk of post sterilization pregnancy in "pomeroy method" is said to be 2 out of 1000. Even in the above decision, the biological reason for automatic reversal of the sterilization is considered as the last and least cause.

16. In the case on hand, the contention of the first defendant before the Trial Court is that had the plaintiff was cautious, she could not have become pregnant. It is also admitted by her in cross-examination that she had not given the warnings and precautions to the plaintiff in writing. Therefore, this court is of the view that the burden heavily lies on the Medical Officer to prove that there was no negligence in performing the surgery. It is too much on the part of the Medical Officer to doubt the genuineness of the plaintiff in contending in the written statement that the plaintiff might have joined the fallopian tube with the intention of having one more child. Such a contention made by the first defendant-Medical Officer when the plaintiff had approached for damages alleging medical negligence on the part of the first defendant itself shows her idea of escapism and lethargic approach. It is beyond imagination that the plaintiff could have ventured to join the fallopian tube by undergoing another process of surgery to get pregnated for the purpose of claiming some damages that too by fighting against the medical world for years together.

17. In view of the above discussion, this court is of the view that the courts below have committed error in shifting the burden of proof on the plaintiff, a folk lady, which certainly vitiates the judgments in challenge and the substantial question of law is answered accordingly…"

IN THE HIGH COURT OF KERALA

State of Kerala v. Santa & Ors.
(2015) 1 KLJ 509
Thottathil B. Radhakrishnan and Babu Mathew P. Joseph, JJ.

A woman belonging to an economically marginalised community underwent a sterilization procedure relying on the assurances given by the doctor and government proclamations that it was a fool-proof method of birth control. Despite this, she became pregnant and delivered a child. In her suit for damages, the trial court gave a finding of negligence on part of the government doctor and held the State vicariously liable for damages. Appeals were preferred by the State challenging the findings of the trial court, as well as the woman questioning the adequacy of relief granted, before the High Court. While disposing these appeals, the High Court also considered whether the State had any liability to compensate persons who undergo the sterilization procedure based on its assurances and suffer owing to its failure, independent of whether such failure resulted from medical negligence.

Radhakrishnan, J.: "Important issues relating to failed sterilisation surgeries conducted in government hospitals or under government programmes are the focal issues for decision in these appeals, which arise from the decree and judgment in a suit for damages instituted by an economically marginalised woman who underwent a mini lap sterilisation surgery in a government hospital, and, thereafter, bore a fourth child, much against the firm belief she entertained, on the basis of the assurance given by the government through its proclamations and by the doctor that she would not conceive after that surgical sterilisation process.

...

5. In setting up her case in that regard, apart from attributing negligence to the doctor, the plaintiff pleaded about the confidence that she had reposed on materials like pamphlets, issued by the government, propagating such sterilisation as an error-free mode of population control. The court below allowed the claim in part and granted her a decree, as against the first defendant, State of Kerala, holding it vicariously liable for the negligence of the doctor.

6. Though a defendant, the doctor who conducted the surgery has not appealed against the impugned verdict; may be because the court below did not decree the suit as against that person. The first defendant - State's appeal is A.S. No. 57 of 1998. Plaintiff sought leave to appeal; as an indigent, on the question of adequacy of damages awarded by the trial court. On being granted leave to do so, her appeal is on file as A.S. No. 263 of 2003.

...

14. If one were to go for a surgical procedure on the particular, assurance as to its credibility, the bare minimum that is required is that the procedure so expounded and extended has to be deemed to be foolproof, to the extent of its such professed nature. Obviously therefore, when it is demonstrated that the surgical procedure carried out on the plaintiff had failed; which is not a fact in dispute; it is an unexplained situation insofar as the plaintiff is concerned. When that happened from the matters under the control of the defendants, it was up to them to prove by cogent evidence, to the satisfaction of the court below, that the situation is not one attributable to the second defendant; as to negligence, neglect, breach of duty and due care and caution. This is inexcusably so, when the situation bespeaks negligence; that is to say, the happening of something which is not warranted or conceived of, by the acumen and diligence expected of the second defendant and the other personnel under the control of first defendant, having particular regard to what stood professed and offered in public domain by the government through Exhibits A7 to A10. In that factual and inferential matrix in the realm of preponderance of probabilities, we are unable to dissuade from concurring with the finding of the court below that the situation bespeaks negligence and that those responsible, had failed to discharge their legal obligation to convincingly explain the situation in hand, to the satisfaction of judicial mind. Therefore, the application of the doctrine of res ipsa loquitor by the court below and the resultant findings rendered in that regard are hereby confirmed.

15. Notwithstanding the finding of negligence as affirmed herein above, we see that there are other legal aspects as well which need to be addressed. We may note that in *State of Haryana v. Saritra*, (2000) 5 SCC 182, the Apex Court dilated on different aspects in relation to tortious liability, including vicarious liability arising out of medical negligence.

16. Though the aforenoted precedent thus held that claim for damages on account of medical negligence cannot be denied, we proceed to consider whether in the case in hand, the State would have any liability even independent of its vicarious liability as regards the tort of negligence committed by its servant.

17. Pitted here are; in one hand, a couple, of which the plaintiff is the female, belonging to the socially and economically challenged sector of this Nation; in the other hand, the government machinery coupled with the scientific wisdom which cannot but be deemed to be available to it from different legitimate and reliable sources, including, the doctor in government service, who conducted the procedure which has led to this litigation.

18. The legitimate expectations of the plaintiff in the situational scenario of her going for the surgical procedure, in absolute faith and confidence that she would be sterile after such procedure cannot but be taken cognizance of. Relying on Exhibits A7, A8, A9 and, A10, the court below held that the defendants had guaranteed the success of the mini lap surgery and had expounded such procedure as a *permanent method* to prevent future pregnancies. The court below specifically noted that *there was no mention* in those pamphlets about the chances of failure of such surgery. *Those pamphlets had carried the clear statement that mini lap surgery is a permanent and successful method of family planning and that there will not be any side effect or defect in that regard*. Those pamphlets had *not even mentioned about the probable chances* of failure of such surgeries. The contents of Exhibits A7, A8, A9 and A10 are declarations made by or on behalf of the Government. They are materials ill public domain on which a citizen is well founded in reposing confidence. Clinching evidence was therefore before the court below to conclude that the plaintiff, innocently, bona fide, and, in absolute good faith/acted in complete and firm belief and faith in the institutional guarantee of the State Government; to which she was subject; as to the credibility and reliability of the surgical procedure that was being carried out on her. She was, thereby implicitly surrendering to the assurance given by the State Government on behalf of the Sovereign…

…

20. The aforementioned reasons based on the materials on record are clinching to confirm the impugned decree on the ground of promissory estoppel as against the State, through the government; adding on to the conclusion already arrived at as to its vicarious liability.

21. The aforesaid position notwithstanding, this-is a-case here certain larger issues of inexcusable importance in the domain of interpretation and application of the provisions of the. Constitution of India, and the laws in India, arise for consideration in the light of the arguments advanced, and haying regard to governance and decisions in its executive domain…

22. In terms of judicial conscience, we are of the view, that we need to proceed to decide on the aforenoted issues in these appeals which are, primarily civil appeals under Section 96 of CPC. This we do because, Whatever be the jurisdictional content and quality of any statutory proceedings; the Constitution is the pinnacle the bedrock and the guiding beacon for the sustinance (sic) interpretation and application of any law sought to be enforced; substantive or procedural.

…

27. The cohesiveness of the provisions of Parts III, IV and IVA of the Constitution of India is such that the fusion of great ideals and principles enshrined as Fundamental Rights, Directive Principles of State Policy and Fundamental Duties excludes any labyrinthine complexity in their understanding and application…The contextual public policy of this Nation is population control and augmentation of food and other resources... In a country where the population is increasing by the tick of every second on the clock and the Government had taken up family planning as an important programme for the implementation of which it had created mass awakening for the use of various devices including sterilisation operation, there is responsibility on the State - See for support *Santra* (supra), particularly paragraphs 37 and 42 thereof as reported in SCC. Though the said judgment rested on foundations as to tortious liability for negligence, the avowed policies relating to population control have other diverse dimensions' as well. The preservation of available resources for the present and future generations has to be ensured. Of equal importance is the fact that the children are given opportunities and facilities to develop in a healthy manner. The State shall strive to promote the welfare of the people by securing and protecting, as effectively as it may, a, social order in which, among other things, economic justice shall inform all the institutions of the, national, life. The State has also the constitutional obligation to raise the level of nutrition and the standard of living of the people and the improvement of public health as among its primary duties. While these salutary provisions flow out of the Constitution of India in its wholesomeness, they are also particularly provided for among the Directive Principles of State Policy as part of Articles 38, 39 and 47 thereof Similarly, Article 4, enjoins, among other things, the constitutional goal to make effective provision for, securing the right to education and to public assistance in cases of undeserved want. Childhood care and education for all children until they complete the age of six years is also a State goal in terms of Article 45 among the Directive Principles. Remember, citizenship is firstly by birth. The constitutional module in which the citizens are placed is such that they have an active role in ensuring the future of the Nation. The cream of the constitutional goals, including the Fundamental Duties of the citizens, are such that when

a citizen lives up to that constitutional expectation, that person would turn to be a vehicle on which the Constitution can safely carry the Nation to its goals. Article 51A enumerates the Fundamental Duties. It; shall be the duty of every citizen of India, among other things, to strive towards excellence in all spheres of individual and collective activity, so that the nation constantly rises to higher levels of endeavour and achievement and a parent or guardian is to provide opportunities for education to his child. This is among the dictates of the Constitution of this Nation to the citizenry. Though it would have been natural for the economically, and therefore socially, marginalised couple, which led the plaintiff to offer herself for the sterilisation process, it cannot be ignored that she was induced by the Government through its propaganda, as part of the national need for population control and thereby to, empower the wholesome growth of this Nation, Therefore, where the person involved undergoes the procedure of sterilization on the advice in public domain that it is a foolproof method, natural failure of a sterilization procedure; even one not amounting to medical negligence; would also fall under State liability in the context of balancing the equations between Fundamental Duties, Directive Principles, of State Policy and Fundamental Rights, when the societal interest also gets involved while ensuring the sterilization of a person in cases of this nature. In this constitutional conspectus, in cases like the one in hand, there, is a constitutional responsibility for the Nation to support the victims of such a situation. This responsibility arises out of the sufferance of the individual citizen for the common good. This is the constitutional responsibility of socialist, democratic republic where common good and welfare guides…When such constitutional responsibility remains undischarged, it amounts to breach of legal duty to compensate. As a corollary, it results in a legal liability, which is absolute in nature. The liability in this regard will rest absolutely on the State, in the legal perspective, in accordance with the Constitution of India and the laws. The liability to make good the damage in such a situation would, therefore, fall as liability on the State, notwithstanding that no element of negligence by the doctor who performed procedure established. The citizen in sufferance, the victim, would thus be entitled to for enforcement of such liability of the State.

28. Onto the question of quantum of damages, it needs to be noted that the plaintiff had to bring up her fourth child born due to the failure of the mini lap surgery. According to her she was in financial need to provide food and clothing and other basic support for that child including for his education and medical support as and when needed. The court below considered different such 'aspects' and granted an amount of Rs. 64,800/- as damages and a sum of Rs. 10,000/- as damages for pain, mental agony and suffering…We are of the view that on a fair estimate this amount is inadequate. Obviously determination of the amount payable as damages in such a case cannot be on the basis of any hard and fast rule...On the totality of the facts and circumstances we are of the view that an amount of Rs. 500/- per month, also foreseeing, the escalation for expenditure, can be made the basis for determination of damages other than for pain mental agony and suffering…It would only be just arid-reasonable to grant an amount of Rs. 15,000/- (Rupees fifteen thousand only) to the mother for the pain, mental agony and suffering/We may here pause, also to recall that Vishnu, plaintiffs' fourth progeny whom she bore as a result of the failed mini lap surgery is no more. She had to; suffer that loss and agony, as well Hence, total amount of damages due is Rs. 1,23,000/-.

…

31. In the result,…

> 4. A.S. No. 263 of 2003 filed by the plaintiff is allowed in part as above: A.S. No. 57 of 1998. filed by the State is dismissed."

IN THE HIGH COURT OF HIMACHAL PRADESH

State of H.P. v. Sushma Sharma
2016 SCC OnLine HP 3429
Dharam Chand Chaudhary, J.

A suit for damages was filed by a woman who became pregnant as a result of failed sterilization and delivered a child. The trial court dismissed the suit as the doctor's negligence was not proved. However, the lower appellate court reversed the decision of the trial court holding the doctor liable for negligence in performance of her duty to inform the woman about the chances of failure of sterilization. In this appeal filed by the doctor and the State Government, the High Court examined whether the doctor had exercised reasonable care and caution in the course of the sterilization procedure.

Chaudhary, J.: "This judgment shall dispose of the present appeal and also the connected one arising out of the judgment and decree dated 16.12.2003 passed by learned District Judge, Solan in Civil Appeal No. 60-S/13 of 2003. It is seen that learned District judge has reversed the judgment and decree passed by learned Senior Sub Judge, Solan in Civil Suit No. 385/1 of 99/97 and decreed the suit in favour of the respondent (hereinafter referred to as the plaintiff) for the recovery of a sum of Rs. 70,000/- with interest @ 9% per annum from the date of filing of the suit against the appellants in these appeals (hereinafter referred to as the defendants) jointly and severally.

2. Plaintiff belongs to village Sainj, Post Office Kandaghat in District Solan, a rural area. She has been married to Ved Prakash of that village. She gave birth to two children out of this wedlock. When in the year 1994, the children born to her were 5 and 1½ years of age, on account of their poverty, the couple decided to undergo sterilization operation. She was advised to undergo family planning operation (tubectomy). The operation was conducted by the 3rd respondent, posted at that time in District Hospital, Solan on 8.12.1994 at Kandaghat. The complaint is that the said respondent while conducting the operation had acted negligently and failed to take all precautions. As a result thereof, the operation turned unsuccessful and the plaintiff became again pregnant. She even gave birth to a male child also.

. . .

15. This appeal has been admitted on the following substantial question of law:

> 1. Whether as the plaintiff/respondent No. 1 has neither pleaded not proved the factum of the alleged negligence and the manner in which the appellant/defendant No. 3 failed to take reasonable care and caution while performing the Tubectomy operation, the suit of the plaintiff is required to be dismissed?

…

23. It is seen that like in *Shiv Ram's case* supra, in the case in hand also, it is not the case of the plaintiff that defendant No. 3 was not competent to perform the surgery and still she proceeded to conduct the same. However, here the allegations are that defendant No. 3 and other supporting staff before and after conducting her tubectomy made her to understand that after the operation, she will neither become pregnant nor any other issue born to her. It is how according to her, defendant No. 3 was negligent and failed in her duty to tell that the operation may fail and she again conceive pregnancy and thereby failed to take due care and precautions before and after the operation was conducted. In the case before the apex Court, it was not the case of the plaintiffs that the doctor who conducted the operation had committed breach of any duty casts on her as a surgeon. This, however, is not the position in the case in hand for the reason that the plaintiff herein has specifically averred as under in the plaint:

> "**3.** .....Prior to the operation defendant No. 3 thoroughly checked up the womb as well as other private parts of the plaintiff and she was found normal in all respects and she was advised by the defendant No. 3 to undergo the operation for tubectomy. At the time of above operation the plaintiff had two issues aged about 5 years and 1½ years. The plaintiff was given assurance that after the operation due care and skill is observed and operation is successful one and in future she will not bear any child."

24. Defendant No. 3 in the written statement though has denied the allegations of negligence attributed to her being wrong, however, not responded to the averments in the plaint that after the operation was over, she assured the plaintiff that while conducting operation due care and skill has been observed and that the operation a successful and also that in future she will not bear any child. Therefore, such averments in the plaint remain uncontroverted…

25. Now if coming to the evidence qua this aspect of the matter, the plaintiff while in the witness box as PW-1 in so many words has proved that field staff before she chosen to undergo the operation had assured that after the operation she will not carry any pregnancy…The doctor assured her that she will be operated upon properly and that after the operation, there will be no scope of any pregnancy and of giving birth to any other child…No suggestion was given to the plaintiff in her cross-examination that neither the field staff nor defendant No. 3 ever assured her that operation was successful and that she will not carry any pregnancy after the operation. Meaning thereby that when the assurance was given to the plaintiff that her operation was 100% successful and that she will not carry any pregnancy in future, she may have not even imagined that she is carrying pregnancy when there was menstrual break. The stand of the defendants is that the rate of failure of family planning operation is ranging between 5-7%, however, the present is a case where the plaintiff was not made to understand the same. Defendant No. 3 who performed the surgery has, therefore, committed breach of the duty casts on her to apprise the plaintiff that the chances of failure of family planning operation were also there… Therefore, the present is a case where defendant No. 3 has failed to perform the duty casts on her as a surgeon to apprise the plaintiff that irrespective of the family planning operation conducted, in case the same fails and she become pregnant again and also that in such a situation she should rush to the hospital for further management. Such facts, however, were not in *Shiv Ram's case* supra before the apex Court and the observations in para 8 of that judgment "***the present one is not a case where the surgeon who performed the surgery has committed breach of any duty cast on her as a surgeon***" take out this case from the sweep of the above said judgment of the apex Court.

26. The further observations of the apex Court in para 25 of the judgment that "***So also, the surgeon cannot be held liable in contract unless the plaintiff alleges and proves that the surgeon had assured 100% exclusion of pregnancy after the surgery and was only on the basis of such assurance that the plaintiff was persuaded to undergo surgery***" also take out the present case from the sweep of the judgment supra because as noticed hereinabove, the plaintiff has satisfactorily pleaded and proved that the defendants at the time of persuading her to undergo family planning operation and even after conducting the operation also assured her about 100% success of the operation and also that she will not carry any pregnancy after undergoing the operation in future…

27. True it is that in terms of the ratio of judgment supra, the failure of the family planning operation provides a valid and legal ground for termination of pregnancy. However, in the case in hand, in view of the assurance given to the plaintiff, she seems to have not thought even in dreams also that she can become pregnant again, inspite of having undergone sterilization operation when menses stopped. Even initially the doctor has also ruled-out the possibility of she having become pregnant. It came to her notice that she is pregnant when she went to district hospital, Solan. The pregnancy at that time was 3-4 months old and as such, defendant No. 3 advised her not to go for termination of pregnancy being dangerous to her life. Therefore, the plaintiff had no occasion to terminate the pregnancy. The plaintiff has, therefore, rightly said in the replication that she could know regarding the pregnancy at a very late stage in view of being under a bonafide belief that there was no question of conception by her after having undergone the operation.

28. It is worth mentioning here that the present is not a case where the surgeon Dr. Maya Ahuja, the 3rd defendant was not competent to conduct the operation but she has otherwise been found to have committed breach of duty cast upon her to advise or guide the plaintiff before conducting her operation or guided her to take post operative precautions such as rushing to hospital at once, if become pregnant and she rather was made to understand that the operation was 100% successful and that she will not bear any pregnancy in future. It is in this way, defendant No. 3 has committed the breach of duty casted on her as a surgeon. The present as such is a case where it is careless and negligent attitude attributed to defendant No. 3 and for that matter the doctor on duty in the hospital at Kandaghat that the plaintiff had given birth to 3rd child. Mr. Verma, learned Senior Advocate representing the plaintiff is, therefore, absolutely justified in claiming that the facts of this case are distinguishable from that in *Shiv Ram's case* before the Hon'ble apex Court.

29. The defendants have heavily relied upon the so called consent form Ext. D-A. It is seen that this document is in English language. The educational qualification of the plaintiff is 9th standard. True it is that as per her own version, she had studied English as a subject in 8th and 9th class, however, in the considered opinion of this Court, a person with qualification as 9th standard, cannot understand the contents of a document like consent form, Ext. D-A. In the replication she filed to the written statement, it is denied that she has voluntarily consented for her family planning operation and rather as per her version, she was made to sign some document without letting her know that there were chances of failure of the operation. Also that, she being illiterate, could not go through the contents of the consent form. As per her version, Ext. D-A is not binding upon her…Ext. D-A may have filled in by the motivator/health worker in the family planning department… Being so, version of the plaintiff that she was made only to put her signature on the consent form seems to be nearer to the factual position…It is also not known that he/she had read over and explained the contents of

this document in vernacular to the plaintiff. Therefore, it would not be improper to conclude that the consent form Ext. D-A was got signed from the plaintiff in routine without apprising her about the contents thereof in vernacular. Therefore, on this score also, no case in favour of the defendants is made out. Learned lower appellate Court has considered this aspect of the matter in its right perspective.

…

31. Now if coming to the prayer in the suit, the plaintiff has claimed the decree for recovery of a sum of Rs. 2,00,000/-. Learned lower appellate Court in the given facts and circumstances has, however, decreed the suit only for a sum of Rs. 70,000/-. The acts of carelessness and negligence as discussed hereinabove are responsible for giving birth to 3rd child by the plaintiff. A sum of Rs. 70,000/- is not even a fraction of the amount required for bringing up a child and to provide him good education as well as settling him in his life, because for this purpose, huge amount is required. It can reasonably be believed that carrying pregnancy and giving birth to a child is a painful process for a woman. Therefore, Rs. 70,000/- is not sufficient to compensate the plaintiff on account of pain and sufferings she had to undergo during the period she was carrying pregnancy and at the time when she gave birth to child. Therefore, in a case of decree of such a meagre (sic) amount, the defendant a welfare state otherwise also should have not raised such a hue and cry. It is observed so by this Court in a case titled the *State of H.P. v. Smt. Satya Devi* RSA No. 43 of 2006 decided on March 11, 2016.

32. In view of what has been said hereinabove, both the appeals fail and the same are accordingly dismissed…"

Endnotes

1 (1995) 6 SCC 651.

2 (1957) 1 WLR 582.

3 Achutrao Haribhau Khodwa v. State of Maharashtra, (1996) 2 SCC 634; Vinitha Ashok v. Lakshmi Hospital, (2001) 8 SCC 731; Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651; Jacob Mathew v. Union of India, (2005) 6 SCC 1.

4 Jacob Mathew v. Union of India, (2005) 6 SCC 1.

5 (1996) 2 SCC 634.

6 2012 SCC OnLine Del 3178.

7 Note: Cases relating to constitutional violations from forced sterilisation, and guidelines arising from cases involving substandard sterilisation are dealt with in Chapter 2, "Contraceptive Information and Services and Government Population Policies." This chapter deals with cases where medical negligence was a ground.

8 (2000) 5 SCC 182.

9 AIR 2003 MP 284.

10 2014 SCC OnLine HP 4829.

11 (2005) 7 SCC 1.

12 Another three judge bench of the Supreme Court followed Shiv Ram in State of Haryana v. Raj Rani, (2005) 7 SCC 22.

13 (2009) 3 SCC 1.

14 State of Haryana v. Raj Rani, (2005) 7 SCC 22.

15 *See for instance* Balwinder Kaur v. State of Haryana, (2009) 2 RCR (Cri) 104; Bimla Devi v. State of H.P., AIR 2009 HP 73; Mala Devi v. State Govt. of NCT of Delhi; 2014 SCC OnLine Del 4839.

16 2016 SCC OnLine HP 3429.

17 The Delhi High Court in Laxmi Devi v. Union of India, (2005) 118 DLT 484, dealt with the issue of contributory negligence on part of a woman, who had not approached the hospital in time after discovering that she was pregnant, making termination of pregnancy risky to her health, and hence, not advisable. She had become pregnant, inspite of having undergone a tubectomy surgery. The Court, taking note of the educational status of the woman and her husband, held that there was no contributory negligence on the part of the couple. It ruled that educational background, economic conditions, lack of awareness, and living conditions should be considered in determining whether there was contributory negligence. In doing so, the court distinguished another decision of the Delhi High Court in Shobha v. Government of NCT of Delhi, AIR 2003 Del 399, wherein the Court had held that the couple were negligent since they had not approached the hospital on getting to know about the pregnancy. The Court in Laxmi Devi ruled that since the couple in Shobha were both government employees, they stood on a different footing to the couple in Laxmi Devi, due to their educational background and general awareness.

18 (2014) 3 MWN (Civil) 785.

19 Achutrao Haribhau Khodwa v. State of Maharashtra, (1996) 2 SCC 634.

20 (2015) 1 KLJ 509.

21 AIR 2015 (NOC 224) 92.

22 (2013) 2 CTC 332.

23 In Ramakant Rai v. Union of India, (2009) 16 SCC 565, the Supreme Court directed the Union of India to prescribe norms for compensating patients in cases of complications following sterilization procedures. It further directed that these norms should be followed uniformly by all the States. Until such norms were formulated, the Court directed that Rs 1 lakh be paid if the patient sterilized dies, Rs 30,000 if the patient is incapacitated, and the actual cost of treatment, where the patient suffers from postoperative complications (however, a ceiling of Rs. 20,000 was fixed). Subsequently, in Devika Biswas v. Union of India, (2016) 10 SCC 733, the Court noted the quantum of compensation awarded for deaths due to sterilization between 2010-13. It directed that the quantum of compensation given under the Family Planning Indemnity Scheme (FPIS) should be made available on the websites of the Ministry of Health and Family Welfare, Government of India, and the respective State Governments. It also directed that the quantum of compensation fixed under the FPIS should be increased substantially. For a discussion on these cases, and their extracts, *See* Chapter 2, "Contraceptive Information and Services and Government Population Policies".

24 (2008) 2 SCC 1.

25 For a discussion on the formula to be applied in cases of medical negligence, *see* V. Krishnakumar v. State of Tamil Nadu, (2015) 9 SCC 388, 399-404.

26 U.N. Office of the High Commissioner for Human Rights, "Status of Ratification Interactive Dashboard—India," http://indicators.ohchr.org/.

27 D*raft Articles on Responsibility of States for Internationally Wrongful Acts, adopted by the Commission at its fifty-third session in 2001 (Final Outcome) (International Law Commission [ILC]), contained i*n U.N. Doc. A/56/49(Vol. I)/Corr.4 (2001)*, Arts. 3-4.*

28 Vishaka v. State of Rajasthan, AIR 1997 SC 3011.