V | D H | Centre for Legal Policy

Holding Healthcare Providers Accountable: Consumer, Civil, and Criminal Mechanisms

December 2023

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The errors, if any, rest with the authors.

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Executive Summary

Executive Summary

Background

The legal mechanisms available to hold healthcare providers accountable for misconduct and negligence in India have not been well studied. Academic discussions revolve around the law laid down through cases brought to the High Courts and the Supreme Court of India. Currently, there is limited exploration of the functioning and effectiveness of the fora more frequently accessed by patients, i.e., consumer, criminal, and civil courts. This study aims to address gaps in the literature by analysing the decisions of these fora alongside the substantive law governing these cases. i.e. consumer protection law, criminal law, and the law of torts.

This report analyses and compares trends across three datasets of judgments which deal with medical negligence. The data was sourced as follows: (a) For consumer law cases, data was sourced from the online portal which officially hosts orders passed by consumer courts across the country ('**ConfoNET**'); (b) For criminal cases, data was sourced from 'eCourts', the official nationwide online database maintained for district-level court proceedings (c) Civil cases from the High Courts and the Supreme Court were obtained through a partnership with a private aggregator of legal information (Manupatra). The data has been analysed on the basis of issues litigated, alleged violations, outcomes, adjudicatory approaches, the rationale applied to determine guilt or liability, remedies awarded, and the time taken to dispose of cases. These findings are interpreted against the backdrop of established jurisprudence and legal literature pertaining to medical negligence.

Key Trends in the Data

- Most consumer cases in the dataset involve issues with the treatment or care provided, with very few being based on infrastructural defects. The majority of the criminal cases were filed under Section 304A of the Indian Penal Code 1860 (death due to negligence). However, a number of cases also included simultaneous allegations of the offences of forgery, cheating, criminal intimidation, conspiracy, and grievous hurt caused due to a negligent act, as well as a few offences under other laws.
- Lower courts tended to decide in favour of healthcare providers in the majority of cases (consumer and criminal), with particularly low conviction rates in criminal cases. Many criminal complaints at the district level were dismissed before commencing trial – primarily on the ground that the prosecution either failed to obtain an expert medical opinion as per guidelines laid down in landmark rulings, or to establish a *prima facie* case of medical negligence. Unlike in the criminal and consumer datasets, the healthcare provider was held liable in more than half of the dataset of tort cases adjudicated by the High Courts.
- Consumer complaints were most often filed against individual practitioners jointly with the concerned healthcare establishments, while criminal complaints tended to focus on individual practitioners alone. Most consumer and criminal cases were filed against private healthcare providers. Tort cases before High Courts saw an overwhelming proportion of defendants / respondents being government healthcare providers.
- Criminal convictions usually went beyond a prison sentence, and fines / compensation of widely varying amounts were awarded in addition to imprisonment. Consumer commissions awarded an even wider range of compensation under various heads, such as physical or mental suffering, litigation expenses, and loss of love and affection; notably, most of them did not specify the rationale / principle followed when calculating compensation.

Takeaways and Recommendations

When adjudicating cases of medical negligence or other deficiencies of service in the healthcare context, courts often underscore the need for expert opinion or literature that may be relied upon in coming to a decision. These are, however, not always available or adequate for the task. The outcomes of cases, the rationale followed, and the compensation amounts awarded in cases of medical negligence vary widely across cases and even between different states, leading to significant inconsistencies in outcomes for litigants. More careful and consistent consideration and analysis is required in order to determine which cases require expert medical opinion, as well as the onus and process of producing such opinion. Further, the apparent reluctance of courts to convict healthcare providers of medical negligence under criminal law raises questions as to the role of this mechanism as a tool of accountability in the healthcare space, and possibly warrants further research.

In order to address issues of medical negligence and improve accountability in the healthcare space, emphasis needs to shift from judicial intervention to healthcare reform by executive action and by improving regulatory frameworks. Healthcare establishments need to be incentivised to develop accessible and effective internal grievance redressal mechanisms so that patients' concerns can be resolved in real-time, avoiding long and expensive legal proceedings. The last chapter of this report sets out key recommendations for the strengthening of grievance redressal mechanisms at healthcare establishments, and the reform of criminal and consumer adjudicatory processes for cases of medical negligence, as follows:

- Issuing guidelines to educate consumer fora, district courts, healthcare providers and establishments about developments in the jurisprudence concerning medical negligence.
- Framing rules under the Consumer Protection Act, 2019 to guide the use of expert opinion and the calculation of compensation in such cases.
- Drafting rules to replace the Supreme Court's guidelines in the landmark judgment in *Jacob Mathew v State of Punjab* (2005) 6 SCC 1 : MANU/SC/0457/2005 (Jacob Mathew).
- Setting up permanent district medical boards to provide expert opinion in medical negligence cases, as per *Jacob Mathew*.
- Framing rules under the Clinical Establishments (Registration and Regulation) Act, 2010 and analogous legislations mandating internal grievance redressal systems at all healthcare establishments.

Introduction

Introduction

"Let not Gods waste their time in litigation" quoted the Madras High Court in its recent judgment on the challenge to the government's order on compulsory rural postings of doctors.[1] These words, in a way, reflect two realities: first, Indian society places its doctors on the same pedestal as Gods, and second, litigation involving doctors is considered undesirable by the judiciary.

Despite these societal attitudes, there continues to be a rise in medical negligence litigation.[2] The Indian Medical Association reported that 24.2% of doctors fear being sued while 13.7 % fear criminal prosecution during most days of the week.[3] The courts have also echoed these concerns about a rise in litigation against doctors and cautioned against frivolous complaints.[4] Existing literature and media coverage[5] suggest an increase in the practice of 'defensive medicine', defined as "medical practice decisions predicated on a desire to avoid malpractice liability, rather than a consideration of medical risk-benefit analysis."[6] While defensive medicine could encourage healthcare providers to be more alert during diagnosis and treatment, it could also trigger an increase in reluctance in engaging with sensitive medical cases.[7]

On its part, the Supreme Court has, in its decision in the landmark case of *Jacob Mathew v State of Punjab*,[8] introduced safeguards against the indiscriminate prosecution of doctors. However, the executive has failed to introduce guidelines in accordance with the court's directions for more than 17 years after the decision,[9] suggesting that it is easier to pay lip service to the demands of medical professionals rather than bring in substantive changes to criminal procedure.

As valid as the concerns of medical professionals may be, at the heart of any healthcare-related dispute are patients and their families. In particular, any loss on account of medical negligence can be a traumatic experience, especially when the outcome is death at the hands of the so-called 'saviours'. In such situations, the law assumes vital importance in providing recompense and justice. A key aim of this report, therefore, is to study the effectiveness of the law in performing this role. Does the law ensure justice to patients who are afflicted by medical negligence? What becomes of hospitals and doctors who fail in their duty to their patients by treating them negligently? Do the courts treat these 'gods' differently from mere mortals? Have the courts successfully struck a balance between upholding patients' rights and protecting doctors from frivolous litigation?

[1] *Hari Vignesh R v The State of Tamil Nadu*, MANU/TN/0513/2023.
[2] Shakti Singh, 'Alarming Rise in Medical Negligence Litigation: Study' *The Times of India* (18 November 2016) <https://timesofindia.indiatimes.com/city/nagpur/alarming-rise-in-medical-negligence-litigation-study/articleshow/55484635.cms> accessed 5 May 2023.
[3] Md. Wasim Ghori, 'How Healthy Are the Doctors? ET *Healthworld* (6 April 2022) <http://health.economictimes.indiatimes.com/health-files/how-healthy-are-the-doctors/5237> accessed 5 May 2023.
[4] In the case of *Martin F D'Souza v Mohd Ishfaq* MANU/SC/0225/2009, the Supreme Court noted that "[w]hile this court has no sympathy for doctors who are negligent; it must also be said that frivolous complaints against doctors have increased by leaps and bounds in our country, particularly after the medical profession was placed within the purview of the Consumer Protection Act." See also *Dr Suresh Gupta v Govt of NCT of Delhi* (2004) 6 SCC 422.
[5] 'Due To Commercialisation And Overburdened Healthcare System, Mistrust And Suspicion On Medical Services Becoming Narratives: CJI' *Outlook India* (27 February 2023) <https://www.outlookindia.com/national/due-to-commercialisation-and-overburdened-healthcare-system-mistrust-and-suspicion-on-medical-services-becoming-narratives-cji-news-265608> accessed 5 May 2023.
[6] Daniel P Kessler and Mark B McClellan, 'How Liability Law Affects Medical Productivity' (2002) 21(6) *Journal of Health Economics* 931e55.
[7] Wayne Cunningham and Hamish Wilson, 'Complaints, Shame and Defensive Medicine' (2011) 20 *BMJ Quality & Safety* 449.
[8] *Jacob Mathew v State of Punjab* MANU/SC/0457/2005.
[9] 'Guidelines on Medical Negligence under Consideration, Says Union Health Ministry' *Deccan Herald* (14 March 2023) <https://www.deccanherald.com/national/guidelines-on-medical-negligence-under-consideration-says-union-health-ministry-1200072.html> accessed 5 May 2023.

The legal mechanisms available for holding healthcare providers accountable for misconduct and negligence in India are woefully undertheorized and understudied. Much of the scholarly discussion is on the law as declared by the constitutional courts.[10] However, there is little discussion in the literature, or otherwise in the public discourse, about the effectiveness of the fora closest to, and most frequently used by patients.

To address this gap, we have conducted an in-depth study of the decisions of criminal courts, constitutional courts and consumer fora — the principal judicial mechanisms through which patients hold healthcare providers accountable. Central and state medical council legislation also provide another avenue of recourse, but these are discussed in a separate report. In any case, they have not been designed to provide compensation to victims, and patients or their families are compelled to pursue judicial remedies by instituting civil suits or filing consumer and criminal complaints.[11]

This report studies two substantive laws: the Consumer Protection Act[12] and the Indian Penal Code (**"IPC"**), under which consumer and criminal complaints are filed respectively. The two laws offer different remedies and mechanisms of accountability. Most importantly, they cover different areas: while consumer courts can award damages for deficiencies in service or unfair trade practices, with medical negligence being a sub-set, Section 304A of the IPC applies only to cases of death by medical negligence.[13] During the course of the study, we also came across a number of High Court decisions where a claim for damages in tort was raised in cases of medical negligence. To lend breadth to the study, we have also included a brief discussion on these cases. Finally, we studied Supreme Court decisions on medical negligence to understand how the law in this field has developed.

In order to understand how these mechanisms work in practice, we collected data from various online sources. Our dataset covers judgments delivered by criminal courts, consumer courts, and constitutional courts. By analysing these datasets and comparing them (albeit in a limited way), we are able to draw inferences about these mechanisms, specifically about the kinds of issues that are litigated, their outcomes, the rationale and methods that courts use to determine liability or guilt, the remedies they offer to the victims, and how long they take to dispose of these cases. We present a comprehensive analysis of the criminal and consumer mechanisms, the unique challenges they present, and the legal frameworks they are based on. Our discussion is substantiated with illustrative examples of court decisions from our dataset and contextualised with the help of judicial precedents. To the best of our knowledge, this report offers the most comprehensive study yet of these healthcare accountability mechanisms under Indian law.

In Part I of this report, we set out the consumer and criminal frameworks, walk you through how we collected our data, and how we set out analysing it. In Part II, we look at different dimensions of these frameworks in practice, from a comparison of how often these mechanisms are used and how.

[10] See K Kannan, *Medicine and Law* (OUP 2014).
[11] Karunakaran Mathiharan, 'Supreme Court on Medical Negligence' (2006) 41(2) *Economic & Political Weekly* <https://www.epw.in/journal/2006/02/commentary/supreme-court-medical-negligence.html> accessed 5 May 2023.
[12] The Consumer Protection Act 1986 has been replaced by the Consumer Protection Act 2019. In this study, we have covered orders passed under both the Acts.
[13] For a discussion of why we study only Section 304A, and not Sections 336, 337, and 338, see text to n 91-93.

1. Understanding the Mechanisms

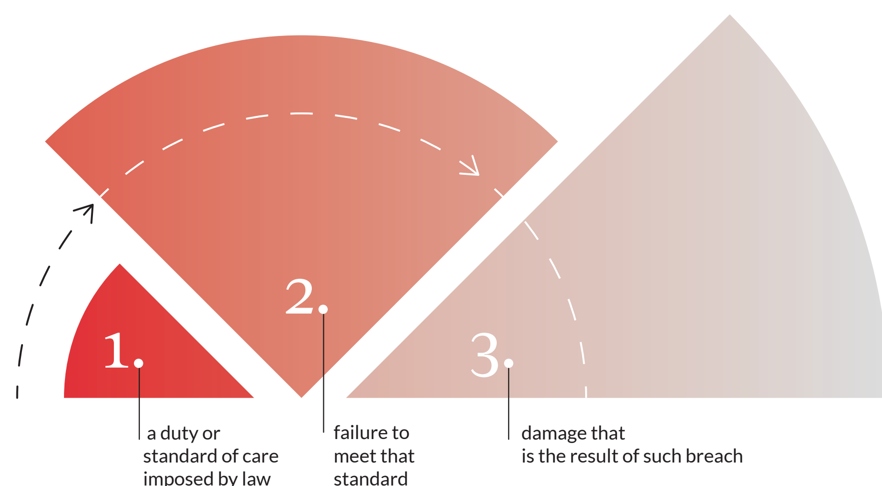
1. Understanding the Mechanisms

Historically, medical negligence fell within the domain of tort law in India.[14] The law of torts is an uncodified branch of common law that evolved out of the jurisprudence propounded by the courts. A tortious wrong consists of three elements: first, a duty or standard of care imposed by law; second, a failure to meet that standard, constituting a breach of the duty; and third, damage that is the result of such breach. Negligence constitutes a specific tort.

For a healthcare provider, this translates to the imposition of a positive duty of care to protect the interests of the patient. As soon as they assume the responsibility to treat, they represent that they possess a degree of knowledge and skill to treat the patient, which any professional would ordinarily possess for that purpose.[15] A breach of this duty by any act or omission of the medical practitioner, which causes damage to the patient, constitutes medical negligence.[16]

The law of torts serves a different purpose from the criminal law. While tort law seeks to compensate the victim for the damages suffered by them, criminal law is a punitive mechanism for punishing the wrong-doer and deterring future offenders. However, one mechanism does not preclude the other. An aggrieved person can initiate proceedings under both laws simultaneously, seeking different remedies. The courts apply different standards to adjudge liability under both these mechanisms. Subsequent sections of this report provide a more detailed discussion of these differences in the specific context of medical malpractice cases.

Fig. 1.1 Three elements of negligence as a tortious wrong



[14] Mathiharan (n 11).
[15] Marc Stauch, *The Law of Medical Negligence in England and Germany: A Comparative Analysis* (Hart Publishing 2008) 34-35.
[16] Ashok R Patil, *Landmark Judgments on Consumer Law and Practice 2008-2020* (Government of India and NLSIU, Bengaluru 2021) <https://consumeraffairs.nic.in/sites/default/files/file-uploads/latestnews/Landmark_Judgments.pdf> accessed 25 May 2023.

Consumer Forums

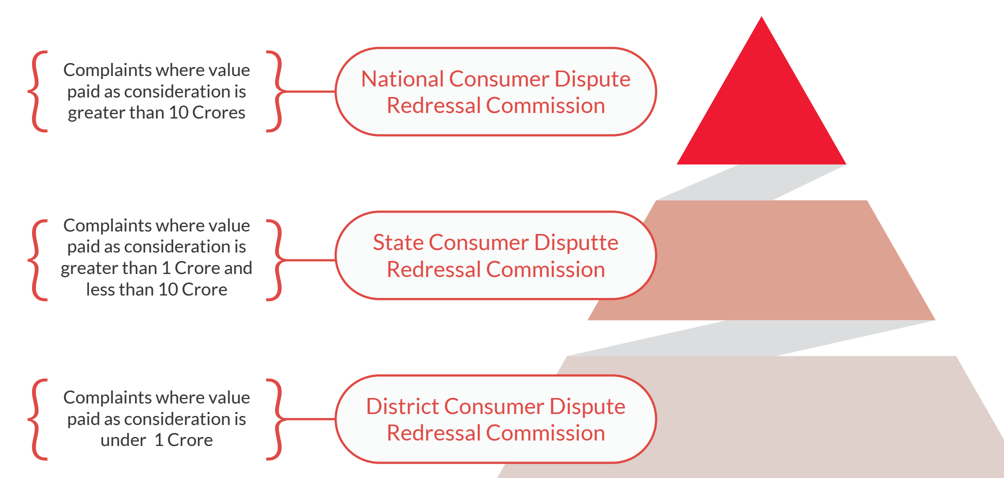
The enactment of the Consumer Protection Act, 1986 codified the tort law on negligence to the extent it is applicable to consumers.[17] While earlier, an aggrieved consumer had to approach a civil court which would apply a complex set of principles, the new legislation provided a simpler and more effective alternative.

Currently, the Consumer Protection Act, 2019 (**"COPRA 2019"**) is in force, having replaced the Consumer Protection Act, 1986 (**"COPRA 1986"**). Any patient availing the services of healthcare providers such as hospitals, clinics, individual medical practitioners, pharmacies and diagnostic centres, who suffers damage by the act/omission of the service provider can file a claim under the Act. The person simply has to file a 'complaint'[18] if the healthcare provider engages in any of the following civil wrongs recognised under the Act:

- the nine categories of unfair trade practices,[19]
- any 'deficiency'[20] in the 'service'[21] they provide, or
- if the consumer is charged for the services in excess of the price agreed between the parties.[22]

The Act sets up a three-tiered structure of consumer fora for time-bound resolution of consumers' disputes. An appeal from the decision of the National Consumer Dispute Redressal Commission (**"NCDRC"**) lies directly before the Supreme Court. Largely, these consumer fora enjoy the same powers as civil courts and can award monetary compensation to the aggrieved consumer. The Commissions are presided over by judges from corresponding tiers in the judicial hierarchy and also include members from a non-judicial background. While the High Courts ordinarily cannot interfere in consumer matters, some exceptions to this exist under their writ jurisdiction. This is discussed at greater length later in the report.

Fig. 1.2 Consumer fora and their pecuniary jurisdictions[23]



[17] Dr A Rajendra Prasad, 'Historical Evolution of Consumer Protection and Law in India A Bird's Eye View' (2014) Journal of Texas Consumer Law 132 <http://www.jtexconsumerlaw.com/V11N3/JCCL_India.pdf> accessed 5 May 2023.
[18] Consumer Protection Act 2019 (COPRA 2019) s 2(6).
[19] COPRA 2019, s 2(47). The Consumer Protection Act 1986 prescribed only six such categories.
[20] COPRA 2019, s 2(11).
[21] COPRA 2019, s 2(42).
[22] COPRA 2019, s 2(6).
[23] Aditya Ranjan & Deepika Kinhal, 'Enforcing Caveat Venditor' (*Vidhi Centre for Legal Policy*, November 2020) <https://vidhilegalpolicy.in/research/enforcing-caveat-venditor/> accessed 5 May 2023.

Applicability to healthcare services

It was initially unclear whether 'service' under the COPRA 1986 would cover healthcare services on account of the fact that they were not expressly mentioned in the definition of the term.[24] It was argued[25] that medical professionals were already subject to disciplinary action by the Indian Medical Council (now the National Medical Commission of India) if they violated the Code of Medical Ethics. However, in *Indian Medical Association v VP Shantha*,[26] the Supreme Court ruled that medical services were a 'service' under the COPRA 1986. This included the rendering of consultations, diagnosis, and treatment, both medical and surgical.

The Supreme Court in this case further clarified that doctors and hospitals who render service without any charge whatsoever to every person availing the service would not fall within the ambit of "service" under Section 2(1)(o) of the Act.[27] The court examined the applicability of the Act to those doctors and hospitals which provide free service to some categories of patients (such as those belonging to economically vulnerable sections) but charge the rest. In such cases, the court held that those patients who receive free services, by virtue of being 'beneficiaries' under the Act, are entitled to the same protection as the paying patients, and therefore fall within the definition of 'consumers'.[28]

The COPRA 2019 does not list healthcare services expressly as a 'service' either even though prior bills had made specific inclusion to this effect.[29] However, medical professionals and healthcare establishments have been held to be included within the ambit of the COPRA 2019, by the Bombay High Court[30] and the Kerala High Court.[31] By refusing to interfere with the Bombay High Court's judgment, the Supreme Court effectively upheld the inclusion of healthcare services under the definition of 'service' and the position of law established by the *VP Shantha* decision continues to hold true.[32]

Scholars,[33] and the Supreme Court itself,[34] have noted the increase in medical litigation under the consumer protection law after the *VP Shantha* judgment. However, there are no official records of the exact number of consumer disputes pertaining to healthcare services or the kinds of issues that patients raise complaints about. We hope to shed light on these aspects in the subsequent sections of this report.

[24] The definition expressly mentioned 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.
[25] *Indian Medical Association v VP Shantha* MANU/SC/0836/1995, [19]. However, in the case of *State of Punjab v Shiv Ram* MANU/SC/0513/2005, [34], the Madras High Court remarked that "[i]n the recent times, professionals are developing a tendency to forget that the self-regulation which is at the heart of their profession is a privilege and not a right and a profession obtains this privilege in return for an implicit contract with society to provide good, competent and accountable service to the public."
[26] *Indian Medical Association v VP Shantha* MANU/SC/0836/1995, [56(1)].
[27] ibid [56].
[28] ibid [45].
[29] Consumer Protection Bill 2018, cl 2(42). See also Dipak K Dash, 'Consumer Bill Draft Removes Healthcare from Services' *The Times of India* (25 June 2019) <https://timesofindia.indiatimes.com/india/consumer-bill-draft-removes-healthcare-from-services/articleshow/69935129.cms> accessed 5 May 2023.
[30] *Medicos Legal Action Group v Union of India* MANU/MH/3641/2021.
[31] *Dr Vijil v Ambujakshi* MANU/KE/2352/2022.
[32] *Medicos Legal Action Group v Union of India* MANU/MH/3641/2021.
[33] Mathiharan n (11).
[34] *Jacob Mathew* (n 8) [10].

Creating a database of consumer cases

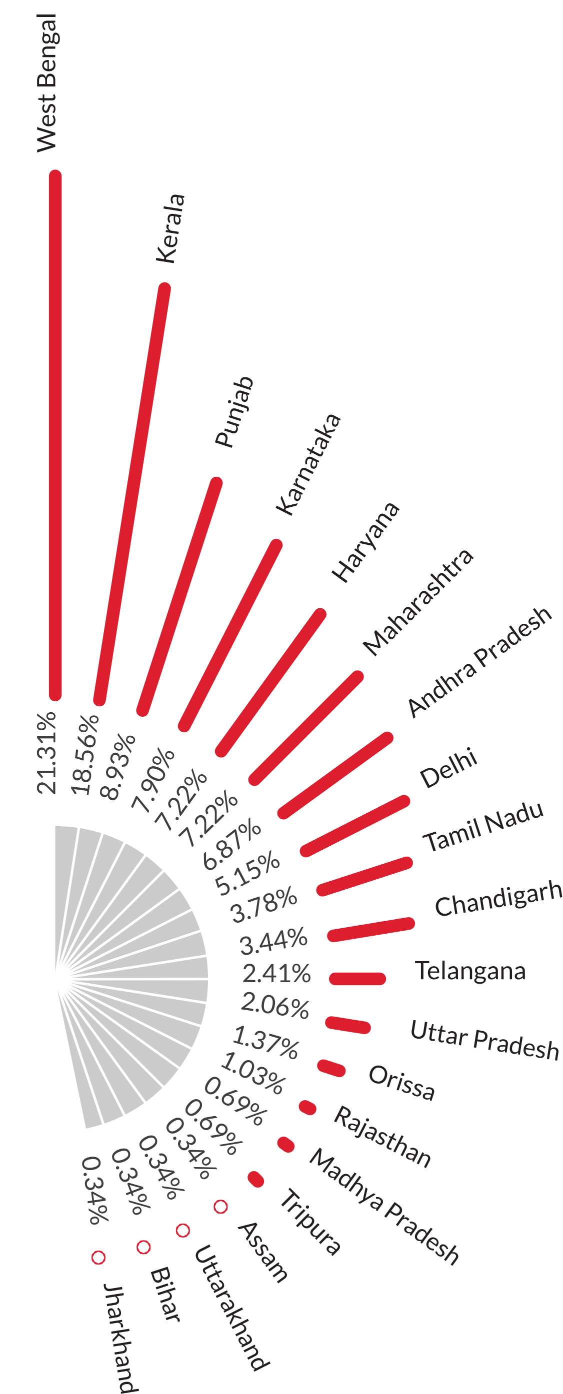
To arrive at a dataset of consumer cases for our analysis, we mined the final orders of all three tiers of consumer fora from the Computerization and Computer Networking of Consumer Forums in Country (CONFONET) for all years since the enactment of the Consumer Protection Act, 1986.[35] This is the official online portal for filing and tracking cases under the Consumer Protection Acts. From the search results, we drew a random proportionate sample of 360 cases and our findings are based on our analysis of these cases. A detailed explanation of our process for collecting, sampling and analysing the cases has been presented in the Annexure.

Overview of the data

Geographical distribution

At the state and district level, the highest number of decisions were delivered in West Bengal (62 cases in the sample, i.e., 21% of the state and district cases) closely followed by Kerala (54 cases, i.e., 19%) while the lowest were from Uttarakhand, Bihar, Assam, and Jharkhand (0.3% each). Interestingly, there is a significant difference in the number of judgments between the two states with the highest numbers of judgments and the third such state, that is, Punjab (26 cases, i.e., 9%).

Fig. 1.3 Geographical distribution of SCDRC and District Fora decisions



[35] 'CONFONET (Computerization and Computer Networking of Consumer Commissions in Country)' <https://confonet.nic.in/> accessed 25 May 2023.

Fig. 1.4 Breakdown of Types of Cases before NCDRC

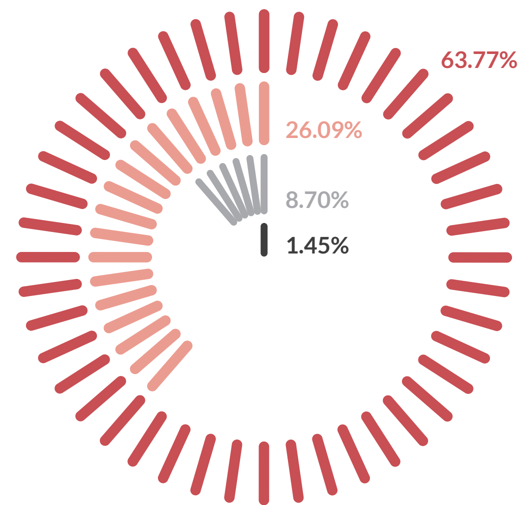
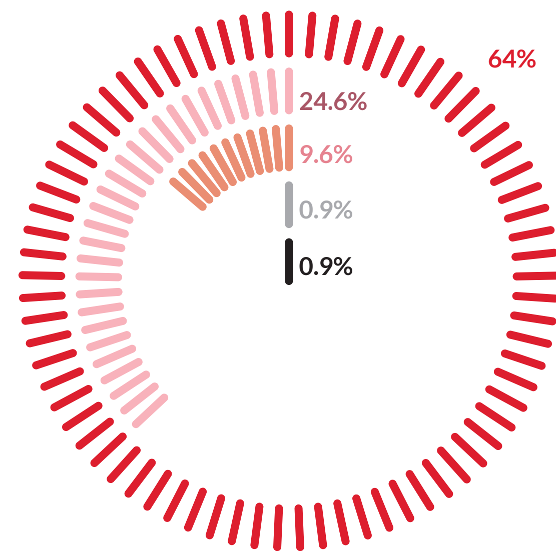


Fig 1.4 shows the types of cases that comprise our NCDRC data. A majority of the decisions were delivered in review petitions, followed by first appeals. About 9% of the judgments pertained to complaints which were directly filed before the NCDRC.

First Appeal
Complaint Case
Review Application
Review Petition

Fig. 1.5 Breakdown of Types of Cases before SCDRC



Revision Petition
Transfer Application
Misc. Application
Complaint Case
First Appeals

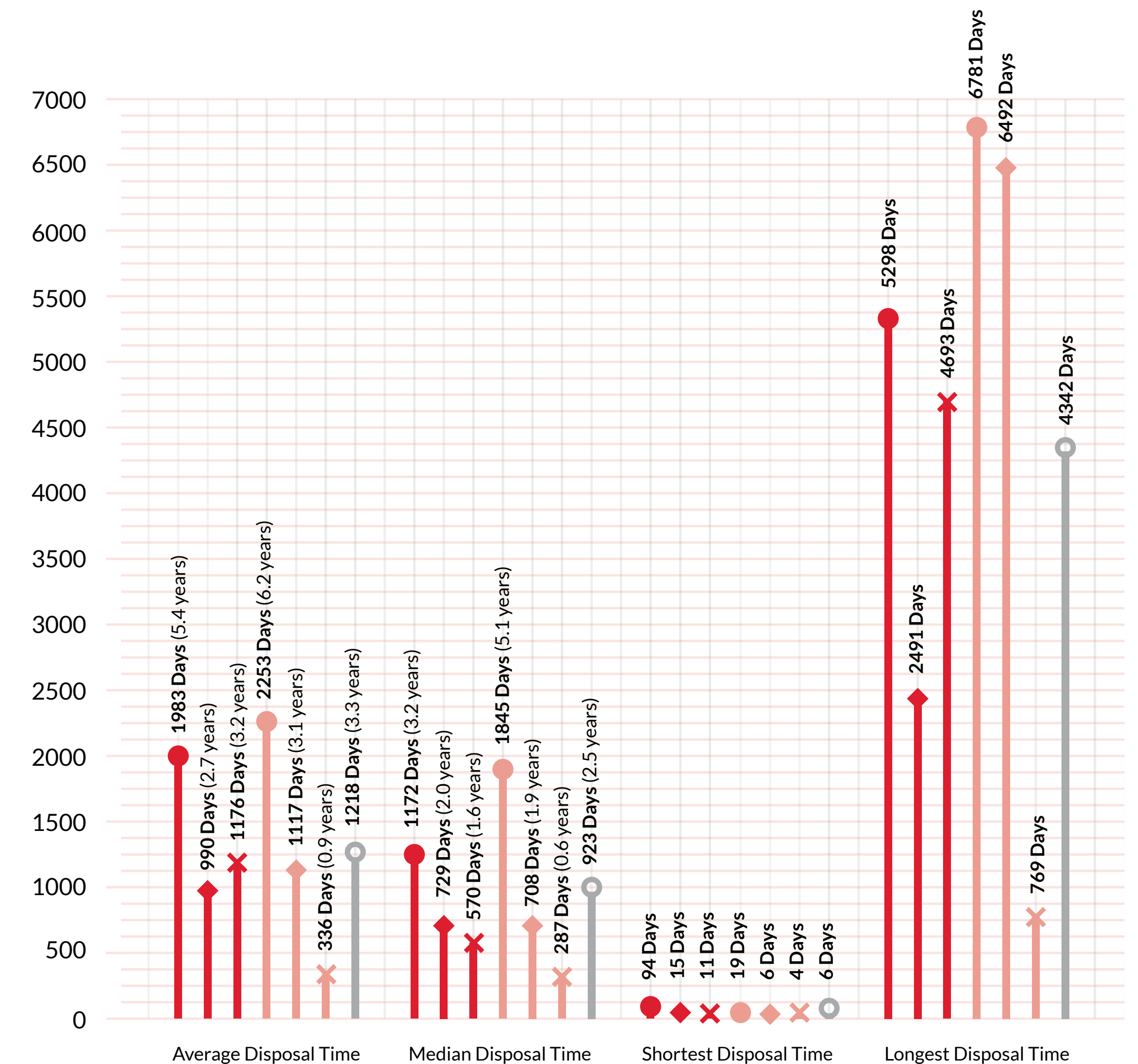
Figure 1.5 shows case types before State Consumer Dispute Redressal Commissions (**"SCDRC"** or "*state commission*"). Most of the cases were first appeals against decisions given by district fora. About 24% of the judgments, on the other hand, arose out of complaints which were directly filed before the state commissions. Naturally, all the judgments from the district fora involved original consumer complaints.

Disposal times

The Consumer Protection Acts of 1986 and 2019 intended to ensure the timely disposal of consumer complaints. They state that the district fora should hear every complaint as expeditiously as possible and endeavour to decide the matter within 3 months where no testing of commodities is required.[36] The same is applicable for original complaints filed before the State Commission[37] and the NCDRC.[38] For appeals before the State Commission and the NCDRC, this desired time period is 90 days.[39]

In reality, consumer fora usually take much longer to dispose of cases.

Fig. 1.6 Disposal time before NCDRC, SCDRC and District Fora per case type



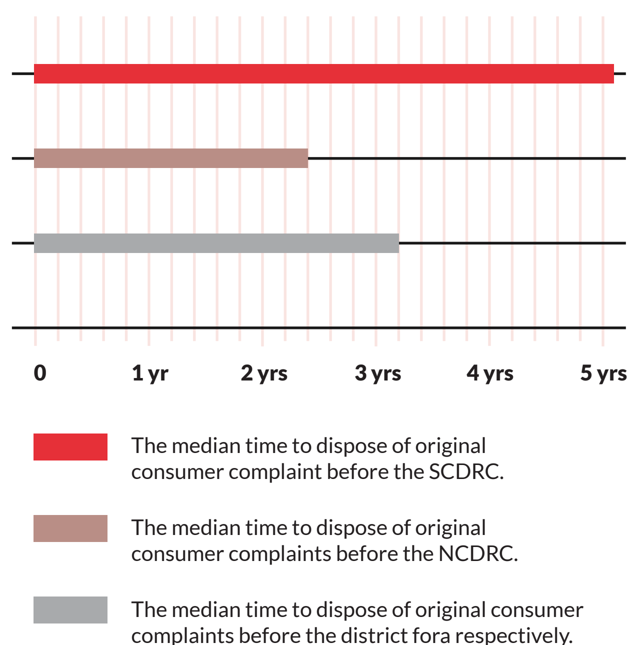
Disposal time before NCDRC per case type
Disposal time before SCDRC per case type
Disposal time before District Fora per case type

Consumer case
Complaint case
First Appeal
Revision Petition

[36] COPRA 1986, s 13(3A); COPRA 2019, s 38(7).
[37] COPRA 1986, s 18; COPRA 2019, s 49.
[38] COPRA 1986, s 22; COPRA 2019, s 59.
[39] COPRA 1986, s 19A; COPRA 2019, s 52.

In our data, on an average, original complaints take a long time to be disposed of. Appeals take comparatively less time, but on an average, the NCDRC and SCDRC take more time to dispose of these than what is recommended under the consumer protection laws. The median time to dispose of original consumer complaints is 3.2 years, 5.1 years and 2.5 years before the NCDRC, SCDRC and the district fora respectively. In other words, only about half of the original consumer complaints against healthcare providers were disposed of within this time period, which is, in any case, significantly longer than that required by the law.

Fig. 1.7 Median disposal time before the NCDRC, SCDRCs, and district fora



Issues litigated

Claims of deficiency in service, primarily relating to medical negligence in diagnosis or treatment were the most commonly contested disputes, with 229 judgments expressly including the phrase 'medical negligence.' Negligence also has a broad connotation, with failure to respect patient rights also being understood as a form of negligence. For example, one category of cases involved the alleged failure of doctors to obtain the informed consent of the patient. Overcharging was another contested issue. Disputes falling under 'unfair trade practice' included allegations of misleading advertisements, failure to provide the agreed services and provide refunds. The phrase 'unfair trade practice' appeared in 59 judgments. Out of these, 35 judgments also included the phrase 'medical negligence'. A clear categorisation of disputes based on issues is difficult since multiple overlapping issues are decided by the fora. For instance, in a particular case, the district forum found the hospital and its directors liable for deficiency of service, negligence and unfair trade practice. This was on account of the fact that the patient had died due to the extreme cold caused by the air-conditioner placed in the room and the hospital manipulated medical reports to cover this up.[40] In the 2019 Act, negligence is now specifically recognised as a form of deficiency in service.[41]

Our analysis of the consumer forum cases showed that there were three broad categories of alleged deficiencies of service in healthcare - forms of medical negligence with issues in diagnosis and treatment/care, issues with competence and quality, and violations of patient rights. In order to capture the nuances and diversity within each category, we filed them under a total of 11 sub-categories, apart from providing options for 'none' and 'not-applicable'. More often than not, each case concerned multiple allegations among the identified sub-categories.

A broad sub-category for 'issue with care or course of treatment' captures the majority (72.8%) of the cases under study. This, along with 'issue with diagnosis' (19.2%) and 'delays in treatment/ testing/ report delivery' (7.5%), forms the bulk of 'medical negligence' cases, as understood in the most traditional sense of errors in judgment and care by healthcare providers, and delays in various aspects of healthcare. 'Overcharging' - charging more than the pre-decided amount or the rate chart - was identified as another category of deficiency in service, and accounted for 4.4% of the cases.

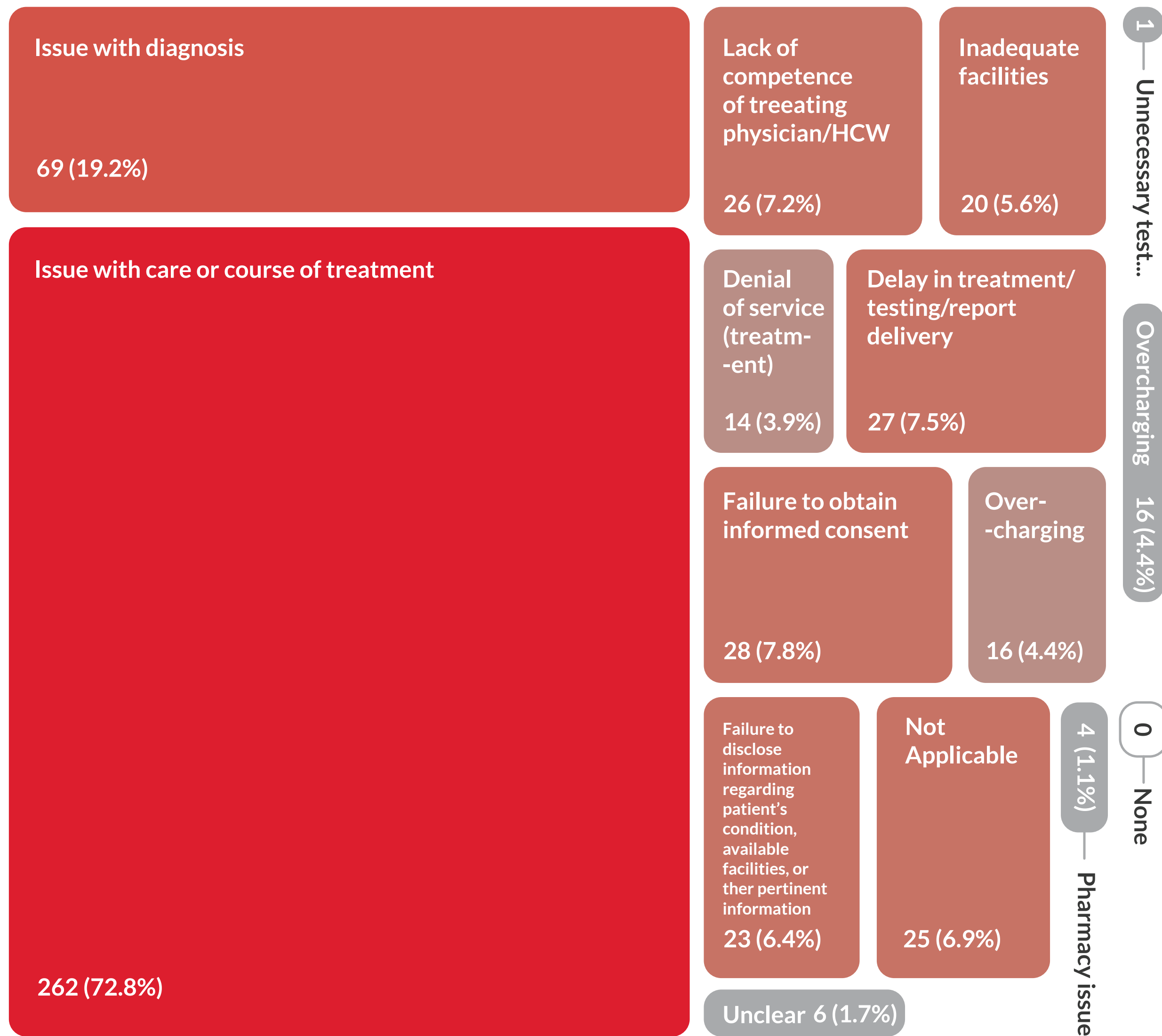
Issues in competence/ qualification of healthcare providers, and quality or propriety of facilities available or provided by healthcare establishments, were captured through two sub-categories, 'lack of competence of treating physician/ health care worker' and 'inadequate facilities', which formed 7.2% and 5.6% of the cases respectively. The lack of an anaesthetist in a surgery requiring anaesthesia is an example of the former category, while inadequate ICU facilities in a critical care hospital would form part of the latter.

Interestingly, quite a wide array of violations of rights recognised under the Charter of Patient Rights have been alleged in these cases. This includes 'failure to obtain informed consent' (7.8%), which may range from inadequate explanation of risks of a medical procedure or treatment options, to conducting sterilisation surgeries without the patient's knowledge. Denial of any part or whole of service/ medical treatment was alleged in 3.9% of the cases. Conducting unnecessary diagnostic tests (0.3%), refusal to provide patient records - generally or at the time of discharge or transfer (2.2%), and failure to disclose pertinent patient/ medical information (6.4%), were other kinds of alleged violations. In the course of our analysis, 'pharmacy issue', i.e. issues with quality or cost of drugs (or sale of different drugs than the ones requested) were identified in four cases.

'Not applicable' was applied to account for those cases in which the alleged deficiency was not the subject of the judgment or order in question, whereas in some cases the allegation was unclear (1.7%).

[40] *Pijush Roy v Naba Jiban Hospital Pvt Ltd* CC/384/2015, District Consumer Disputes Redressal Forum, Kolkata Unit - II (Central) (20 July 2016) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=4%2F623%2FCC%2F384%2F2015&dtofhearing=2016-07-20 > accessed 5 May 2023.
[41] COPRA 2019, s 2(11)(ii).

Fig. 1.8 Categories of violations or deficiencies of service alleged before consumer fora

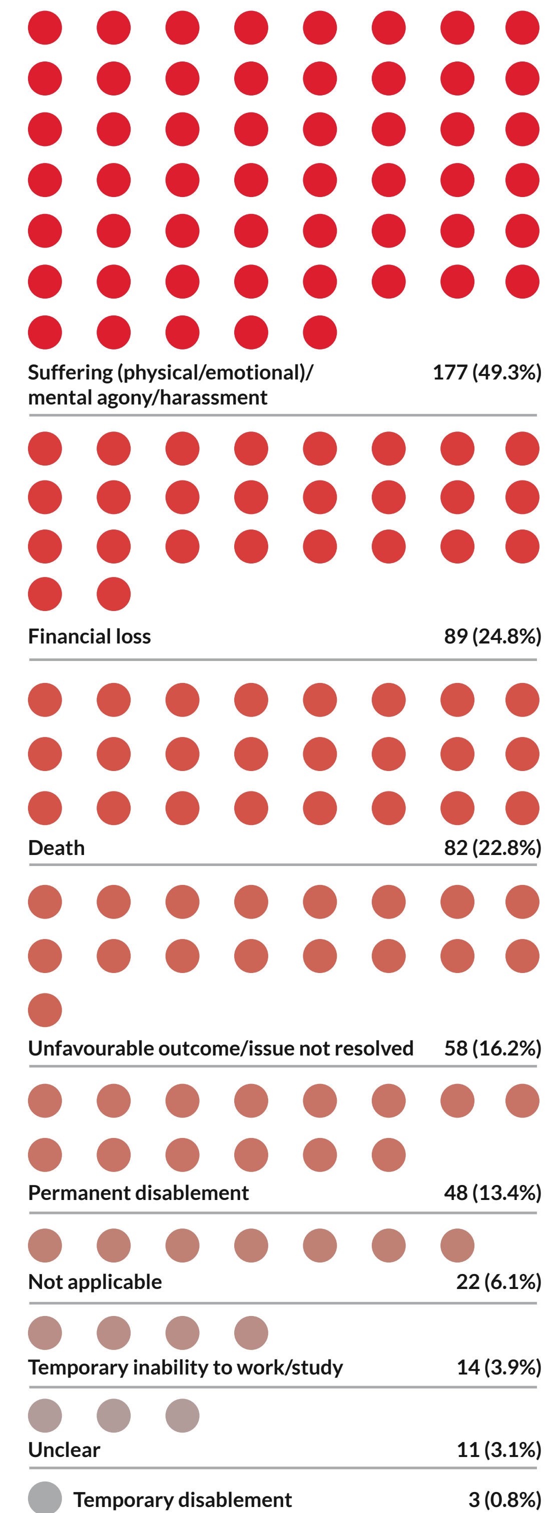


Alleged violation or deficiancy of service 360 responses

Further, we noticed a range of alleged harm in the cases in our database. Mental or physical suffering, agony, and harassment was the most commonly alleged harm, making up 49.3% of our cases. This was followed by allegations in 22.8% of the cases that the medical negligence/ deficiency in service resulted in the death of the patient. Financial loss (24.8%), whether or not connected to a temporary inability to work/ study (3.9%) formed another major category.

Permanent disablement and temporary disablement made up 13.4% and 0.8% of the database respectively. Matters in which there was a general alleged harm of discontentment or dissatisfaction with the service, were included under 'unfavourable outcome/ issue not resolved' (16.2%). For cases not decided on merits, 'not applicable' was the chosen option (6.1%), whereas in 3.1% of the cases the alleged harm was not amply clear.

Fig. 1.9 Categories of harm alleged before consumer fora



From the database, 79.7% of the cases were decided on merits, while 8.9% of the cases were decided on technical grounds such as limitation and jurisdiction. 11.1% of the cases were decided on other legal principles which were not connected to the facts of the case - for example, whether a matter alleging deficiency of service initiated by a now-deceased complainant (who was the patient in question) could be continued by their representatives. 6 cases were clubbed under 'not applicable', in cases which were remanded to other (usually lower) fora for reasons other than jurisdiction-related issues.

Fig. 1.10 Bases of decisions by consumer fora

Criminal Courts

The criminal law is the most rigorous and exacting mechanism through which societies deter and punish undesirable behaviour. In the context of the medical profession, the general offences are contained in the IPC under provisions such as 304A (Causing death by negligence), 336 (Act endangering life or personal safety of others), 337 (Causing hurt by act endangering life or personal safety of others), 338 (Causing grievous hurt by act endangering life or personal safety of others), 420 (Cheating) and 471 (Forgery).

Besides these, offences specific to the medical sector are provided for in laws like the Medical Termination of Pregnancy (MTP) Act, 1971, and the Transplantation of Human Organs and Tissues Act (THOTA), 1994. Of these, we have specifically chosen to study section 304A at the district court level. This provision makes it a crime to cause the death of any person by doing any rash or negligent act not amounting to culpable homicide, and punishes it with imprisonment (simple or rigorous) for a maximum of two years, or a fine, or both. We have chosen this because the National Crime Records Bureau also records the deaths caused by medical negligence based on the complaints received by the police under this provision.[42] While we focused on this particular provision at the district court level, we examine a broader range of offences at the High Court level given the relative ease of accessing judgments from the higher judiciary.

Protection from indiscriminate prosecution

If prosecuted, medical professionals are subjected to a rigorous and protracted trial. They may suffer considerable social stigma and personal distress. Since the edifice of the medical profession is trust, any loss of reputation will unquestionably be professionally damaging.

As a result, the courts have repeatedly taken a sympathetic view towards medical professionals, introducing protection for doctors from knee-jerk, indiscriminate prosecution. They were concerned with the possibility of frivolous complaints in general, as well as the use of malicious prosecutions by a civil complainant to force the doctor to settle the matter.[43] By the very severity of its nature, criminal law requires the prosecution to prove medical negligence 'beyond reasonable doubt', as opposed to the less rigorous civil standard of 'preponderance of probabilities'. The Supreme Court has additionally introduced layers of protection for medical professionals by laying down the following guidelines in the *Jacob Mathew* case:

- On private complaints - A private complaint may not be entertained unless the complainant has produced prima facie evidence before the court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor.
- On First Information Reports (**"FIRs"**) - The investigating officer should, before proceeding against the doctor accused of a rash or negligent act or omission, obtain an independent and competent medical opinion, preferably from a doctor in government service qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion regarding the facts collected in the investigation. The Supreme Court relied on the English case of *Bolam v Friern Hospital Management Committee*[44] to place the onus to produce independent medical opinion on the complainant. This criteria is commonly referred to as the *Bolam test*.
- On arrest - Unless their arrest is necessary for furthering the investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor proceeded against would not make themselves available to face the prosecution unless arrested, the arrest may be withheld.

In effect, the Supreme Court has prohibited the prosecution of medical professionals in a routine manner merely on the basis of the allegations raised in a complaint. Instead, before initiating prosecution, police officers have to satisfy themselves that at least a credible prima facie case can be made out against the medical practitioner and in order to ascertain this, they must obtain the expert medical opinion of a doctor. Thus, even to register an FIR against a medical practitioner, a preliminary inquiry is mandatory.[45]

In *Martin F. D'Souza v Mohd. Ishfaq*,[46] the Supreme Court extended this protection to consumer cases, holding that when a complaint is received against a doctor or hospital by the Consumer Fora, then notice can only be issued after a competent doctor reports that a prima facie case of medical negligence is made out. However, in its later decision in the case of *V. Kishan Rao v Nikhil Super Speciality Hospital*,[47] the Supreme Court took a different view. In this case, the court observed that if the conditions laid down in *Martin F. D'Souza* were followed strictly, it would dilute the speedy and simple remedy envisaged under the consumer protection legislation. Instead, it held that where medical negligence was alleged before a consumer forum, the questions should be judged on the facts of each case. It noted that *there cannot be a mechanical or straitjacket approach that each and every case must be referred to experts for evidence*. Thus, the protection afforded to medical professionals under criminal law has not been extended to consumer cases.

Creating a database of criminal cases

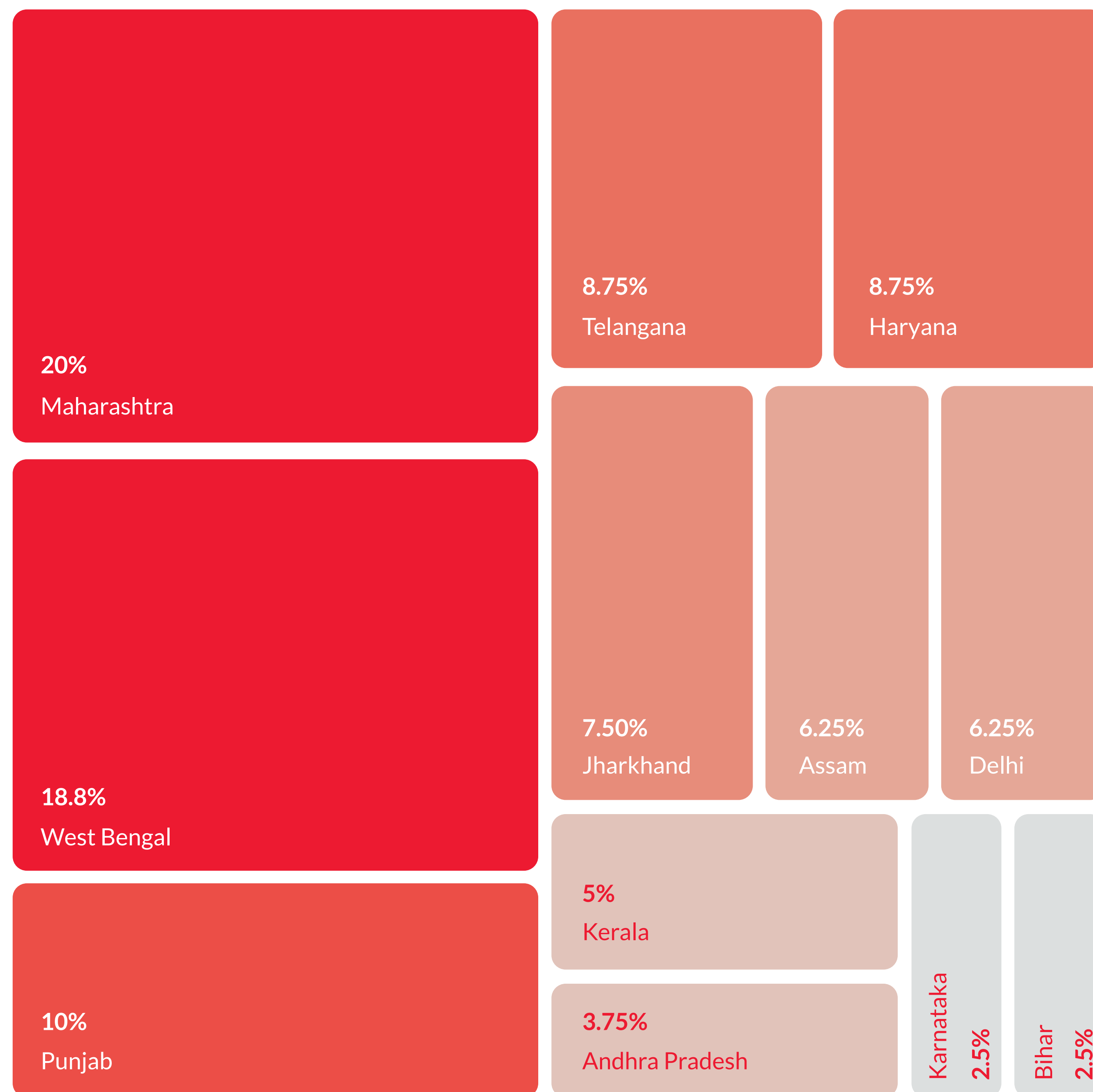
We scraped the district e-Courts website[48] for the final orders or judgments of all cases that had been disposed of under Section 304A of the IPC, that is, where the death of the victim was caused by the alleged negligence of the healthcare provider. We obtained 60,934 results from this search. However, after cleaning up the data, only 80 judgments were found to be relevant for the study. This does not include judgments which were delivered in languages other than English. A detailed methodology for collecting and cleaning the data is available in the Annexure.

[42] National Crime Records Bureau, Crime in India 2020: Statistics, vol 1 <https://ncrb.gov.in/sites/default/files/CII%202020%20Volume%201.pdf> accessed 5 May 2023.
[43] *Jacob Mathew* (n 8).
[44] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
[45] *Lalita Kumari v Government of Uttar Pradesh* MANU/SC/1166/2013.
[46] *Martin F D'Souza v Mohd. Ishfaq* MANU/SC/0225/2009.
[47] *V Kishan Rao v Nikhil Super Speciality Hospital* MANU/SC/0332/2010.
[48] 'Official Website of District Court' <https://districts.ecourts.gov.in/> accessed 25 May 2023.

Overview of the data

We observe that the highest number of judgments were from Maharashtra (16 cases, i.e., 20%) while the lowest were from Karnataka and Bihar (2 cases each, i.e., 2.5% each). The state-wise distribution of the judgments is shown in figure 1.11.

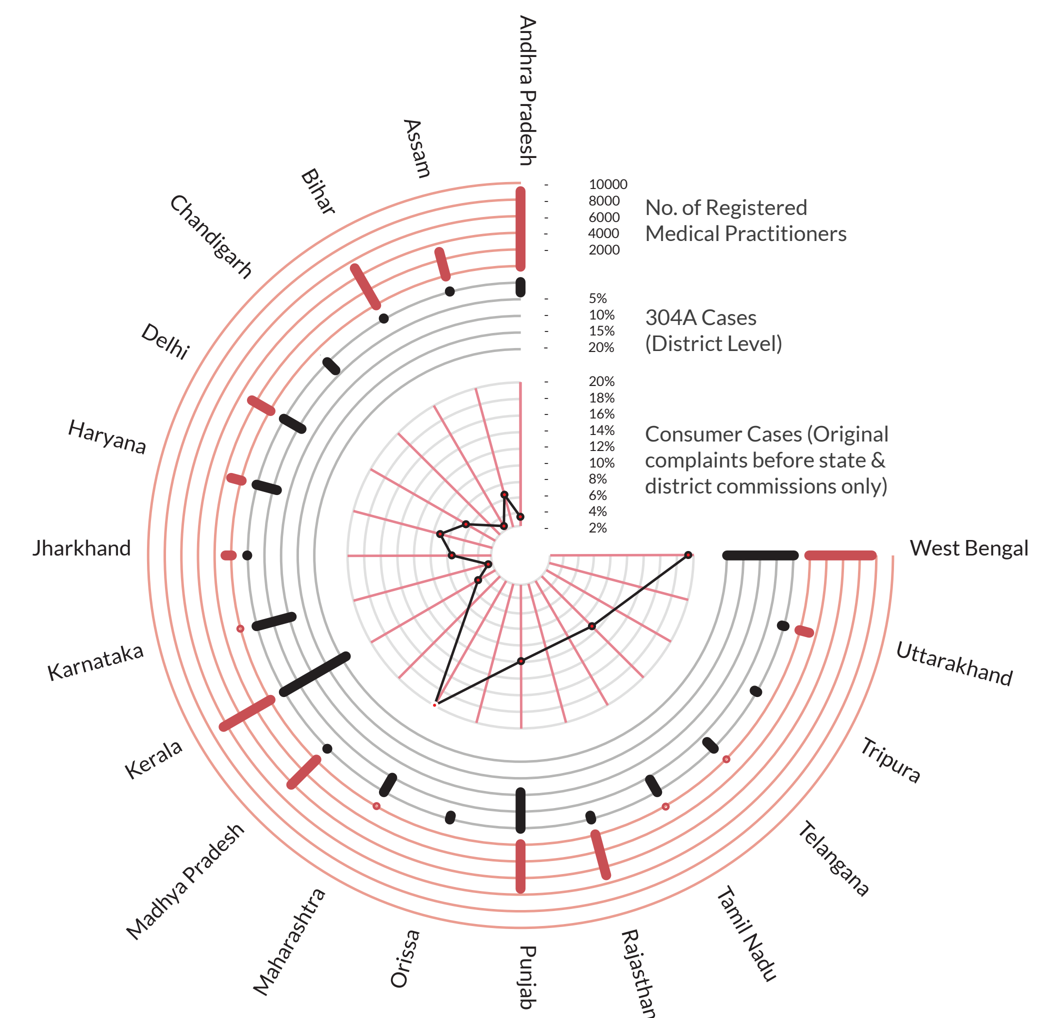
Fig. 1.11 Geographical distribution of criminal cases before district courts



We calculated the average disposal time of the 76 cases where the date of filing and date of decision were available. On average, a case was disposed of in 5.3 years (1931 days) with the longest taking about 17 years and the shortest taking 57 days.[49] The median time taken to dispose of a case was 4.8 years (1739 days) which means that about half the cases were disposed of within the first five years of filing.

Figure 1.12 shows the number of criminal judgments from the district courts and judgments from the state and district consumer fora in cases where original complaints were decided. The number of registered medical practitioners[50] in each state has also been represented for context.

Fig. 1.12 Snapshot of geographical distribution of Consumer (state and district) and Criminal (district) cases plotted against the number of registered medical practitioners in each state



[49] According to a study, the average disposal time for a criminal case in a subordinate court in India is 3.4 years. See Arunav Kaul, Ahmed Pathan, and Harish Narasappa, 'Deconstructing Delay: Analyses of Data from High Courts and Subordinate Courts,' in S Vidyasagar, H Narasappa and RS Tirumalai (eds), *Approaches to Justice in India: A Report by DAKSH* <https://www.dakshindia.org/Daksh_Justice_in_India/19_chapter_01.xhtml#:~:text=The%20average%20time%20taken%20to,the%20final%20order%20or%20judgment> accessed 5 May 2023.

[50] As recorded in the Indian Medical Register available on the official website of the National Medical Commission, see 'Indian Medical Registry Search' (*National Medical Commission*) <https://www.nmc.org.in/information-desk/indian-medical-register/> accessed 06 May 2023.

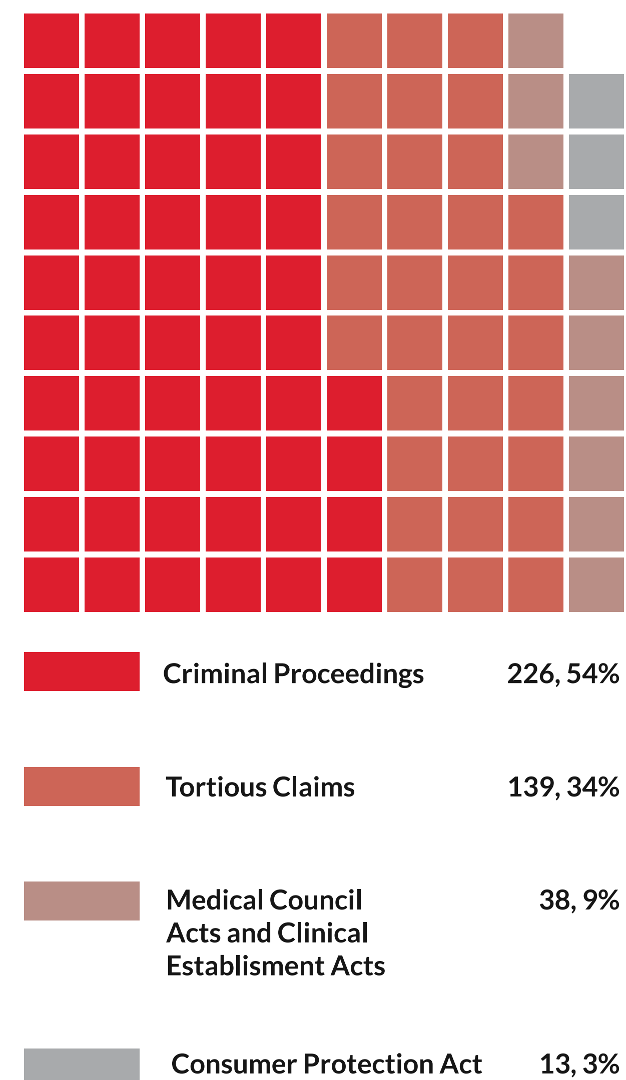
The Constitutional Courts

The consumer fora and the trial courts act as the first point of contact of patients and their families with the justice system. To that end, studying the operation and approach of these authorities is significant in evaluating the efficacy of the two mechanisms. However, the High Courts and the Supreme Court exercise influence on these lower fora not only by setting precedents but also by reviewing the procedures and decisions of the lower fora.

The High Courts

We entered into a collaboration with Manupatra,[51] a private online aggregator of legal information including court orders. Manupatra shared with us the details of High Court judgments from across all years containing the phrase 'medical negligence'. Of the 1301 High Court judgments that were shared, we found only 416 of these to be relevant for our study, i.e. dealing squarely with the issue of medical negligence.[52] Since our search phrase was broad, we observed a diverse variety of issues being litigated across civil and criminal cases. This included suits for damages filed under the tort of negligence, challenges to the decisions of relevant state medical councils and the Medical Council of India, challenges to suspension orders under laws regulating clinical establishments, criminal appeals and petitions to quash criminal proceedings.

Fig. 1.13 Types of Litigation before High Courts



Consumer

High Courts have not been included under the scheme of consumer law. Only the district, state and national fora have the jurisdiction to entertain consumer complaints and any appeal from the decision of the NCDRC lies before the Supreme Court.[53] Despite this, the High Courts can entertain challenges to the orders of consumer fora in the exercise of their writ jurisdiction under Articles 226 and 227 of the Constitution. The Supreme Court, in a recent case, has further clarified that the NCDRC (and by extension the state and district fora) can be said to be a 'tribunal' for the purposes of Articles 226/227 and therefore the High Court can interfere in the orders given by the NCDRC in appeal from decisions of the state fora.[54] Therefore, grievances against the decisions of the consumer fora are maintainable before the High Courts within the limited parameters prescribed in Articles 226 and 227.

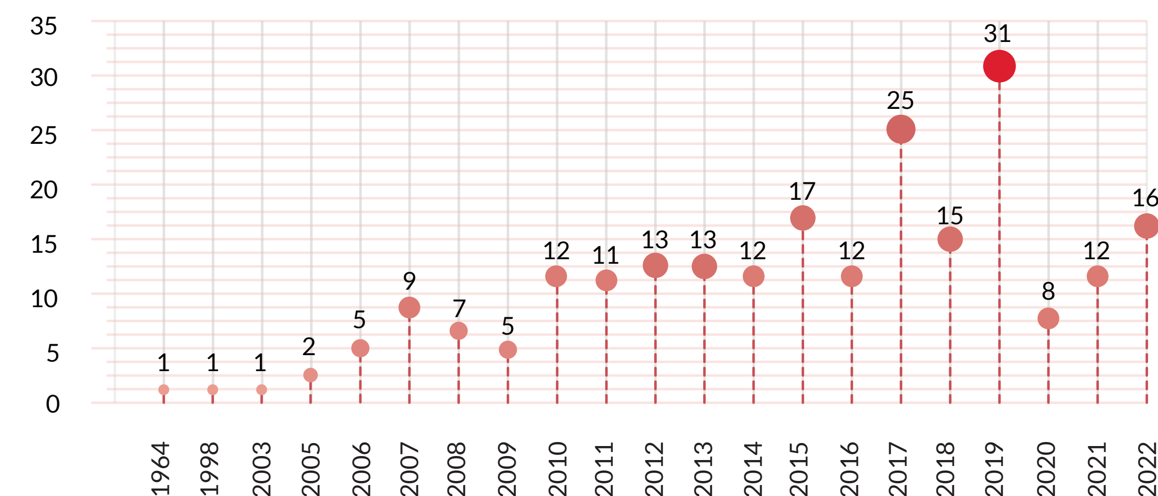
Given the exceptional nature of this power, it is no surprise that we found only 13 judgments from the High Courts which arose directly from proceedings under the Consumer Protection Acts. The High Court was called upon to decide on the applicability of the Act in certain disputes, to command the consumer forum to decide a long pending matter, to intervene in interim orders passed by the fora or otherwise decide jurisdictional issues. Very rarely do the High Courts enter into substantive discussions on the merits of the case.

Criminal

On the criminal side, our search within High Court judgments was far broader than our search for cases before the district courts. We simply searched for the phrase 'medical negligence' on Manupatra, obtaining 226 judgments involving criminal proceedings initiated against healthcare providers.

While the majority of the cases were filed under Section 304A of the IPC, we found cases of medical negligence where offences under other provisions of the criminal law had also been alleged. These included the offences of forgery, cheating, criminal intimidation, conspiracy and offences under sections 336, 337 and 338 of the IPC which deal with grievous hurt caused due to a negligent act. There were a few cases which were filed for offences committed under other laws like the Prevention of Corruption Act, 1988 and the Medical Termination of Pregnancy Act, 1971.

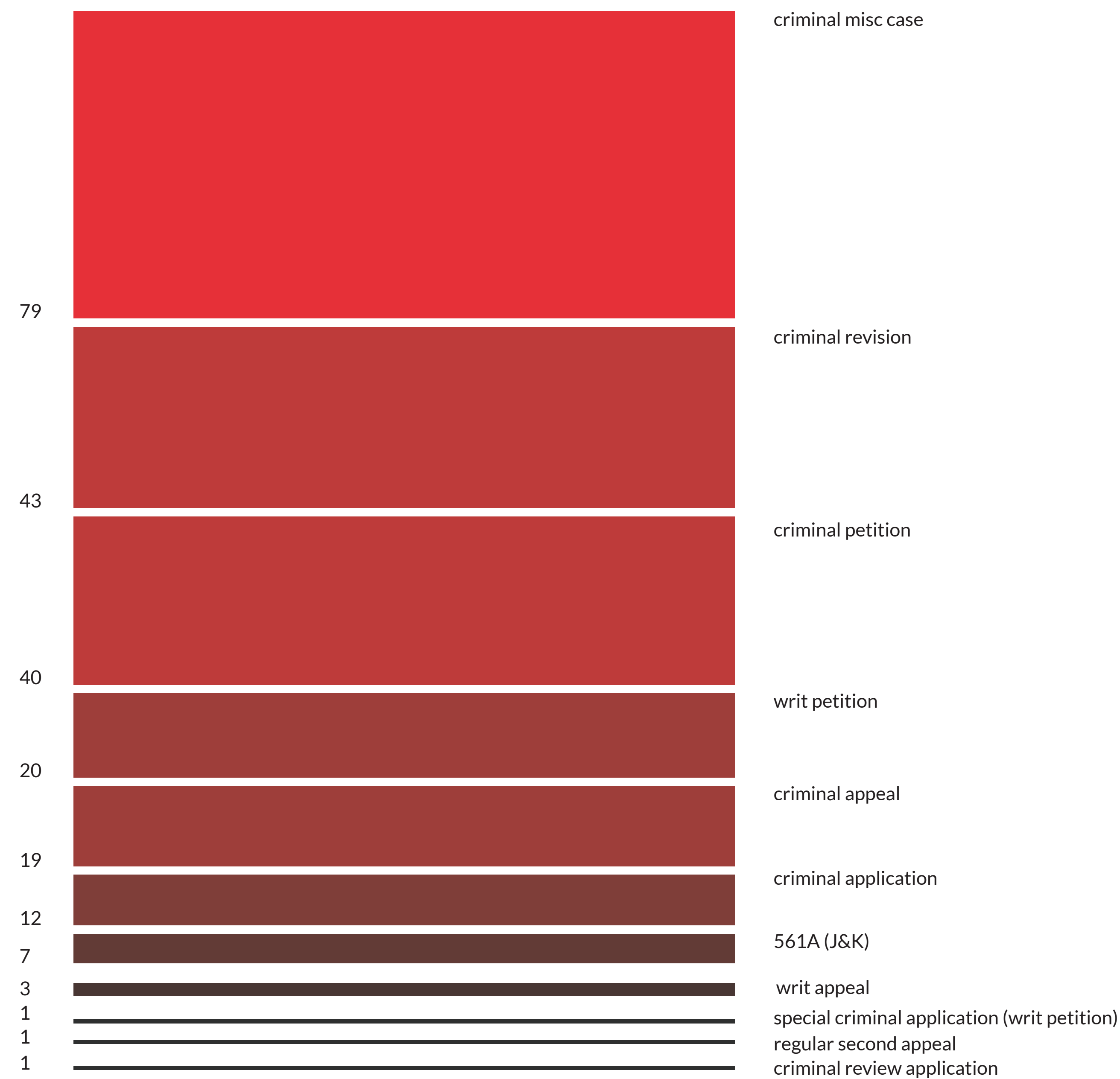
Fig. 1.14 Number of criminal medical negligence cases in our dataset disposed of by High Courts by year



[51] Manupatra <https://www.manupatrafast.in/>.
[52] *See* Annexure for details on the procedure followed for filtering the irrelevant cases.
[53] COPRA 2019, s 67; COPRA 1986, s 23.
[54] *Ibrat Faizan v Omaxe Buildhome* (P) Ltd, MANU/SC/0642/2022.

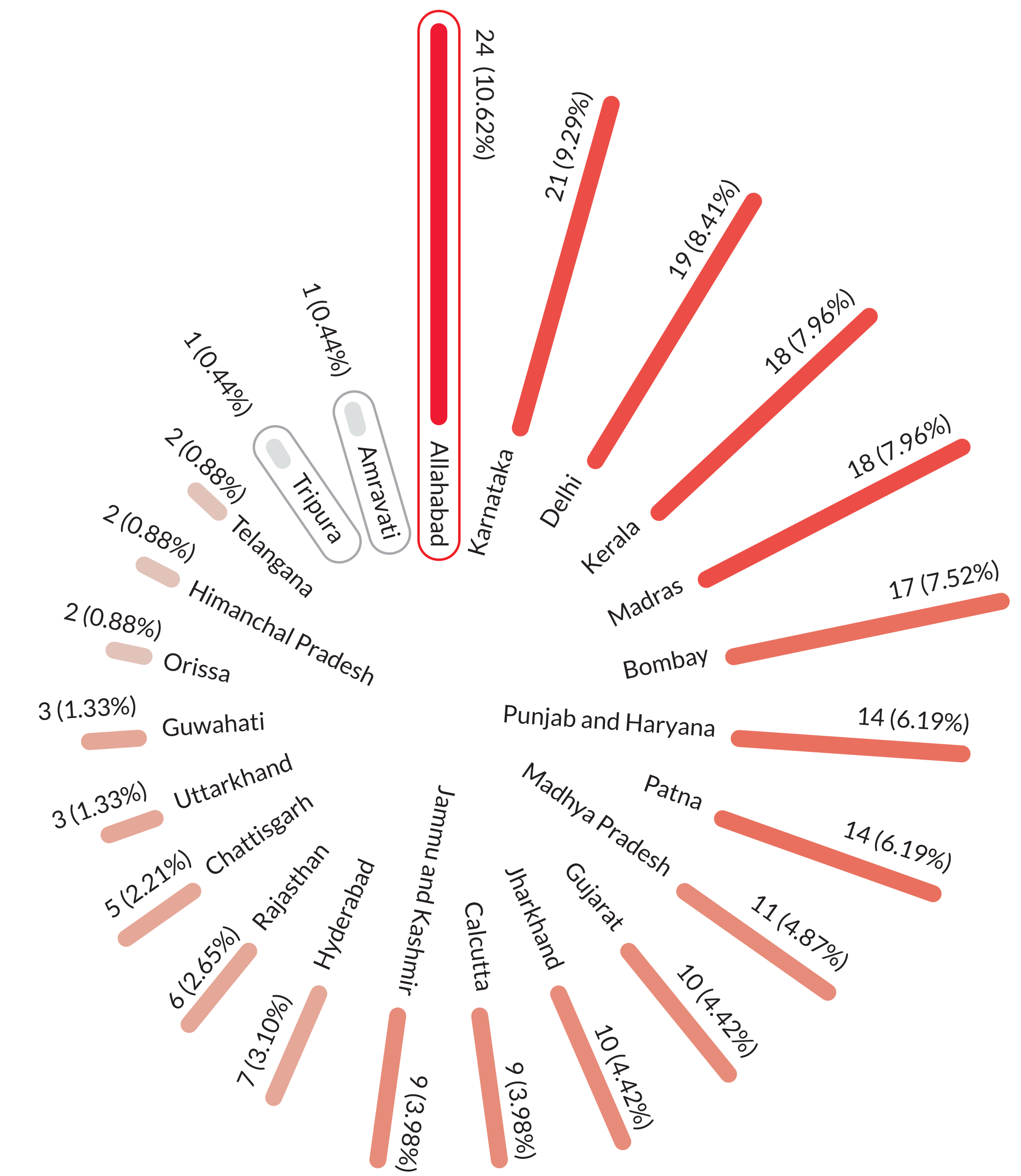
In terms of types of cases, 35% of the cases were miscellaneous petitions usually seeking the quashing of FIRs or ongoing proceedings at the district level. In a few cases, the intervention of the High Court was sought regarding the admissibility or improper appreciation of certain evidence before the district court. Finally, there were 19 (8%) appeals against judgments of district courts where the guilt of the accused had been adjudicated after a proper trial and appreciation of facts and evidence. A breakdown of these case types in our data is given in figure 1.15.

Fig. 1.15. Types of criminal medical negligence litigation before High Courts



The maximum number of judgments in our dataset were delivered by the Allahabad High Court (10.62%) and the fewest were by Tripura and Amravati (Andhra Pradesh) High Courts (0.44%).

Fig. 1.16 Geographical Distribution of HC Criminal Cases



Supreme Court

The Supreme Court is the final adjudicatory body for all criminal and consumer cases. It sits in judgment over cases involving substantial questions of law. Manupatra shared with us 107 judgments from the Supreme Court which contained the words 'medical negligence' across all years. After a preliminary review of the data, we found 62 of these judgments to be relevant for this study. Each of these judgments has been read in detail for an in-depth analysis.
Of these, about 42 were primarily concerned with a consumer dispute while 11 primarily involved criminal liability. However, Supreme Court judgments often undertake overlapping discussions on the tests to attribute civil or criminal liability and the corresponding burden of proof. For instance, the *Jacob Mathew* case was primarily concerned with a 304A complaint while the *Kusum Sharma* case was a consumer dispute. Yet both these judgments have contributed to the jurisprudence of civil and criminal medical negligence significantly. Therefore we thought it more appropriate to consider the judgments of the Supreme Court holistically rather than categorising them into consumer or criminal cases.

In order to determine which of the Supreme Court decisions have contributed the most to the jurisprudence on medical negligence in the country, we recorded the number of citations of each of the 62 cases, as displayed on Manupatra. These citations span across all fora for which Manupatra maintains a database, including criminal and civil courts, and all consumer fora. The list of the most often cited Supreme Court decisions is given in table 1.4. We will be referring to the landmark judgments in later sections of the report to substantiate the discussion wherever appropriate.

Table 1.4 List of most cited Supreme Court judgments on Manupatra

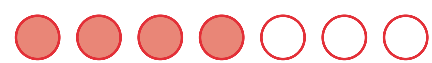
No. of citations on Manupatra	Name and citation of the case
993	*Jacob Mathew v State of Punjab* (05.08.2005 - SC) - MANU/SC/0457/2005
200-300	*Indian Medical Association v VP Shantha* (13.11.1995 - SC) - MANU/SC/0836/1995
	Martin F. D'Souza v Mohd. Ishfaq (17 . 02 . 2009 - SC)- MANU/SC/0225/2009
	Kusum Sharma v Batra Hospital and Medical Research Centre (10 . 02 . 2010 - SC) - MANU/SC/0098/2010
	Malay Kumar Ganguly v Sukumar Mukherjee (07 . 08 . 2009 - SC) - MANU/SC/1416/2009
	Nizam Institute of Medical Sciences v Prasanth S Dhananka (14 . 05 . 2009 - SC) - MANU/SC/0803/2009
100-200	*J. J. Merchant v Shrinath Chaturvedi* (12 . 08 . 2002 - SC) - MANU/SC/0668/2002
	Spring Meadows Hospital v Harjol Ahluwalia through K. S. Ahluwalia (25 . 03 . 1998 - SC) - MANU/SC/1014/1998
	V. Kishan Rao v Nikhil Super Speciality Hospital (08 . 03 . 2010 - SC) - MANU/SC/0332/2010
	Savita Garg v The Director, National Heart Institute (12 . 10 . 2004 - SC) - MANU/SC/0882/2004
	State of Punjab v Shiv Ram (25 . 08 . 2005 - SC) - MANU/SC/0513/2005

[55] *Kusum Sharma v Batra Hospital and Medical Research Centre* MANU/SC/0098/2010.
[56] As on 5th February 2023.

Limitations

This study relies on the judgments of criminal courts and consumer fora to understand how these mechanisms ensure the accountability of healthcare providers. There is no particular provision in the IPC which criminalises the wrongs committed specifically by healthcare providers. The same is true under the Consumer Protection Acts. Instead, both these laws include general provisions on offences and civil wrongs. Since we are specifically interested in the application of these provisions to healthcare providers, one of the major challenges that we faced was the absence of an exhaustive and cohesive dataset on the subject. Therefore, we had to undertake the laborious exercise of extracting a large number of cases under these laws and then weeding out cases which were not relevant to this study. We ultimately created datasets containing only cases where the substantive issue was wrongdoing by a healthcare provider. Each of these cases was then read manually to draw out qualitative information for analysis. By having followed this process, we acknowledge that this study might be prone to certain limitations despite our best efforts to ensure rigour. These have been listed in the Annexure.

2. Analysing the Mechanisms



2. Analysing the Mechanisms

Having developed an understanding of the mechanisms and the datasets in the previous section, this chapter attempts an in-depth analysis of the working of these mechanisms. In the sections below, we undertake a detailed discussion on the decisions of the courts in criminal and consumer cases, across district courts, consumer fora and the High Courts. With the help of established legal principles and literature, we examine the reasoning adopted by the courts to arrive at their conclusions. We also look at the kind of remedies which courts and the consumer fora have awarded to successful complainants in the backdrop of leading precedents. Finally, we evaluate the nature of healthcare providers against whom such litigation has been initiated.

A. How many criminal cases actually make it to trial?

Given the low number of criminal judgments in our district court data, it might appear that doctors face a low threat of prosecution in cases of medical negligence. Further, it might also be tempting to conclude that the likelihood of an aggrieved patient/ patient's family approaching a consumer forum is much higher as compared to them filing a criminal complaint. However, at this stage, the validity of these assertions cannot be confirmed unless we examine an additional consideration.

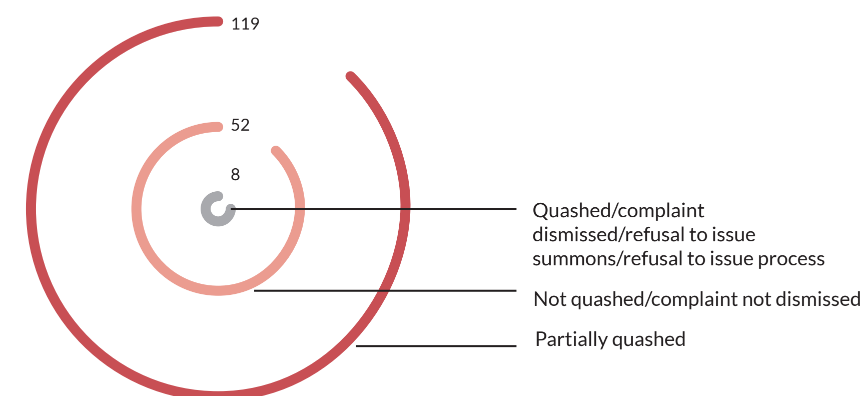
As mentioned in the methodology, our district court data comprises only final orders or judgments which are delivered after the completion of the full trial. This means that any cases which are settled out of court, any summary disposals or even revision petitions have not been included in this dataset. In reality, as we shall now see, this number of final orders is a very small proportion of all the complaints or FIRs that are filed against healthcare providers. A large number of these complaints do not get a full trial, i.e., the court does not adjudicate upon the merits of the case after a detailed appreciation of facts and evidence.

This becomes evident on examination of the High Court cases on criminal complaints of alleged 'medical negligence'. We found that 176 out of 226 cases before the High Courts involved quashing of complaints and proceedings.

High Courts are constitutional bodies with wide powers. One such power is to issue orders to prevent an abuse of the process of any court or to secure the ends of justice under section 482 of the Code of Criminal Procedure, 1973 (CrPC). The Supreme Court has repeatedly held that this is a special power which must be used sparingly by the High Courts in the rarest of rare cases.[57] This provision is often invoked to quash FIRs and criminal proceedings where it appears that a criminal complaint has been filed for a civil offence, or where no prima facie case is established which merits a detailed prosecution. The Supreme Court has held that 'Section 482 is designed to achieve the purpose of ensuring that criminal proceedings are not used as weapons of harassment.'[58] Besides Section 482, our data reflects that the parties also approached the High Courts by way of writ petitions and revision petitions to seek similar reliefs.

Of the 179 judgments mentioned above, it was either the healthcare provider who had approached the high Courts to quash existing charges, proceedings, order of summons, or even FIRs (primarily under section 482, CrPC), or it was the patient or their family who had approached the High Court by way of revision petitions to pray for a reversal of lower court orders where the judge had refused to take cognizance or issue summons against the healthcare provider.

Fig. 2.1 Outcomes in petitions and applications for quashing of charges, proceedings, etc.



Of all such petitions, we found that in 67% of the cases, the court decided the case in favour of the healthcare provider.

One of the primary grounds for exercising this exceptional power and quashing the FIR or the proceedings against healthcare providers has been the failure to follow the guidelines laid down in *Jacob Mathew* and *Martin D'Souza* at the time of trial and investigation. In order to avoid the alleged harassment of doctors through frivolous criminal and civil complaints, these two cases had laid down that it was imperative for the prosecution to obtain the expert opinion of medical professionals specialised in the field in which medical negligence had been alleged. Only if the expert body opines that there is a prima facie case of medical negligence can the investigating agencies or the courts proceed against the doctors. Our data shows instances of the courts quashing proceedings where the investigating agency had not obtained the opinion of an independent medical board before initiating prosecution.[59] Similarly, where the medical board had opined that no medical negligence could be ascertained in a particular case, then the HC quashed the proceedings.[60]

[57] *Paramjeet Batra v State of Uttarakhand* MANU/SC/1108/2012; *Neeharika Infrastructure Pvt Ltd v State of Maharashtra*, MANU/SC/0272/2021; *Usha Chakraborty v State of West Bengal* MANU/SC/0079/2023.
[58] *Kapil Aggarwal v Sanjay Sharma* MANU/SC/0131/2021 .
[59] *See Shashikala v Jaffar* MANU/KA/1368/2019; *AK Gupta v State of Uttar Pradesh* MANU/UP/4000/2018; *Ramya v State of Karnataka* MANU/KA/2754/2017; *KC Vidyarthi v State of Bihar* MANU/BH/0301/2016; *Narendra Prasad v State of Bihar* MANU/BH/1479/2012.
[60] *See Veeresh v State of Karnataka* MANU/KA/8955/2019; *A Padmaja v State of Telangana* MANU/HY/0497/2018; *Ghulam Ahmad Wani v State of Jammu and Kashmir* MANU/JK/0373/2017; *Thiravium v L Wilfred Raj* MANU/TN/0666/2017; *Jaiprakash v State of Rajasthan* MANU/RH/0424/2016.

> One of the primary grounds for exercising this exceptional power and quashing the FIR or the proceedings against healthcare providers has been the failure to follow the guidelines laid down in Jacob Mathew and Martin D'Souza at the time of trial and investigation

> A second supplemental ground for quashing is the failure of the prosecution to establish a prima facie case against the healthcare provider

A second supplemental ground for quashing is the failure of the prosecution to establish a prima facie case against the healthcare provider. In the exercise of its powers under Section 482, the HC does not undertake a detailed examination of all the evidence. Instead, it merely reviews the pre-trial evidence to see if, on the face of the record, all ingredients that would constitute the commission of an offence are made out. Where it appears that the chances of a conviction are bleak or impossible, the court can preliminarily quash the case.[61] The burden of proving that there is sufficient material available that may prove guilt lies on the complainant in criminal negligence cases. The complainant must establish a case on the record to prove that the healthcare provider was grossly negligent or reckless in their conduct. If the court on initial examination of the prima facie evidence finds that no case is made out against the healthcare provider to establish the charges, the case may be dismissed pre-trial.[62]

From the High Court judgments that we studied, it is evident that a large number of criminal complaints or FIRs which are instituted against healthcare providers are simply dismissed pre-trial. This at least partially explains why the number of judgments in the district courts data is low.

[61] *Madhavrao Jiwaji Rao Scindia v Sambhajirao Chandrojirao Angre* MANU/SC/0261/1988.
[62] See *Manipal Hospital v Binayak Bhattacharjee* MANU/KA/0718/2021; *Satish Midha v State of Jharkhand* MANU/JH/0769/2019; *Kunal Sanyal v State of West Bengal* MANU/WB/1338/2011; *Sanjeev v State of Madhya Pradesh* MANU/MP/1054/2007; *Chhaya Rastogi v State of Uttar Pradesh* MANU/UP/3906/2017.

B. How do courts reach their decisions?

Standards for Ordinary Negligence and Medical Negligence

The law imposes different kinds of duties of care on persons performing different roles. It expects all individuals of sound mind to act as ordinary persons would; in other words, to act reasonably. In case of medical professionals, as an English court said in *Bolam v Friern Hospital Management Committee*, "*...where you get a situation which involves the use of some special skill or competence," the law expects such a person to act as an "ordinary skilled man exercising and professing to have that special skill".*[63] According to the court, this has a number of implications. First, "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 a competent man exercising that particular art." Second, whether an act by a doctor has exercised that skill is based on the "*standards of reasonably competent medical men at the time*." Third, there may be a variance of opinions in the medical community (i.e. there may be one or more proper standards) and as long as the doctor meets one of those 'proper' standards, they have not acted negligently.

Under *Bolam*, the question of whether the doctor had violated a standard of care was a fact to be determined on the expert opinion of medical professionals who gave evidence before the court. The role of the courts was to ascertain the contents of a "respectable" body of professional medical opinion, not to judge its correctness.[64] This remained true until *Bolitho v City and Hackney Health Authority*, where the court ruled that even though the expert medical opinion must be considered reasonable for most matters, a body of professional opinion could be substituted by the judgment of the court in rare cases.[65] In particular, the court held that "in a rare case, if it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible."

Nearly a decade after *Bolam*, the Indian Supreme Court in *Laxman Balkrishna Joshi v Trimbak Bapu Godbole* held that the duty imposed on a medical practitioner was that of a "reasonable degree of care."[66] This care was to be exercised in deciding whether to undertake the case,[67] what treatment to give,[68] and in the administration of that treatment.[69] Unlike in *Bolam*, the court was not relying entirely on the body of medical opinion, as it was not at issue in the case.

[62] *See Manipal Hospital v Binayak Bhattacharjee* MANU/KA/0718/2021; *Satish Midha v State of Jharkhand* MANU/JH/0769/2019; *Kunal Sanyal v State of West Bengal* MANU/WB/1338/2011; *Sanjeev v State of Madhya Pradesh* MANU/MP/1054/2007; *Chhaya Rastogi v State of Uttar Pradesh* MANU/UP/3906/2017.
[63] (1957) 1 WLR 582.
[64] *Maynard v West Midlands Regional Health Authority* [1985] 1 All Er 635.
[65] (1996) 4 All Er 771.
[66] *Laxman Balkrishna Joshi v Trimbak Bapu Godbole* MANU/SC/0362/1968.
[67] See for instance, *Poonam Verma v Ashwin Patel* MANU/SC/0530/1996 (a homoeopathic doctor was held negligent when he prescribed an allopathic treatment, as he was under a statutory duty not to enter into the field of any other system of medicine).
[68] See for instance, *Juggankhan v State of Madhya Pradesh* MANU/SC/0078/1964 (a registered homoeopath was held to be negligent for administering a treatment not recognised under his system of medicine, and whose effects on a human being he had not studied).
[69] ibid [11].

However, in *Jacob Mathew v State of Punjab*, the Supreme Court reiterated the standard laid down in *Bolam* of "*the ordinary competent medical practitioner exercising an ordinary degree of professional skill*."[70] Echoing *Bolam*, the court said that "*the fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge*." Neither a mere deviation from normal professional practice,' nor a 'mere accident,' nor an 'error of judgment' are negligence.[71]

It established guidelines for the prosecution of doctors in cases of criminal negligence extensively relying on the reasonable doctor test laid down in *Bolam*. *Jacob Mathew* is the court's most full-throated endorsement of the *Bolam* test. While previous cases hew close to *Bolam* in their language, they do not endorse it in such explicit terms.[72] As it stands, this is the most cited precedent in medical negligence cases.

As our analysis suggests, it has been cited substantively in 21 out of 62 cases in the Supreme Court. Further, it has been cited in 167 out of 226 criminal cases in the High Courts that we analysed. In the lower judiciary, however, it has been cited in only 11 out 80 cases. While criminal prosecution against doctors is the major contention in *Jacob Mathew*, its applicability goes beyond criminal cases. It has been cited in 39 out of 139 tort cases in the High Courts. In the consumer court cases too, *Jacob Mathew* has been cited in 36 out of 360 cases.

Standards for Civil Negligence and Criminal Negligence

In *Dr Suresh Gupta v Govt of NCT of Delhi*, the court drew a distinction between the different levels of negligence required for civil and criminal prosecution in medical negligence cases.[73] The accused in *Suresh Gupta* had performed a medical procedure incorrectly. The court noted that while the act was negligent and the accused could be held liable in tort, "his carelessness and want of due attention and skill cannot be described to be so reckless or grossly negligent as to make him criminally liable." They drew this distinction despite the fact that Section 304A of the IPC does not distinguish between degrees of negligence.

In *Jacob Mathew*, the court affirmed that negligence had degrees, and held that in order to find someone criminally liable for negligence, it must be gross or culpable negligence, and the rashness must be "of such degree as to amount to take a hazard knowing that the hazard was of such degree that injury was most likely imminent."[74] A case of medical negligence under Section 304A cannot be decided using the principle of *res ipsa loquitur*, i.e., the court cannot say that 'the facts speak for themselves'; the prosecution must rely on medical evidence and expert findings.[75]

[70] *Jacob Mathew* (n 8) [18-25].
[71] ibid [25].
[72] *See Achutrao Khodwa v State of Maharashtra* MANU/SC/0600/1996 ("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 the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence."). See also *AS Mittal v State of Uttar Pradesh*, MANU/SC/0004/1989 ("A mistake by a medical practitioner which no reasonably competent and careful practitioner would have committed is a negligent one.").
[73] *Dr Suresh Gupta v Govt of NCT of Delhi* MANU/SC/0579/2004, [24]. This distinction was affirmed in Jacob Mathew (n 8).
[74] *Jacob Mathew* (n 8) [14].
[75] ibid [27].

C. What decisions do courts reach?

As far as the substance of outcomes is concerned, our data suggests that most criminal prosecutions end favourably for healthcare providers. Of the 80 prosecutions at the district level, only 5 resulted in a conviction, whereas, in 75 cases, the accused was acquitted. That is a conviction rate of just 6%.

At the High Court level, out of the 27 cases where a final determination on the guilt of the accused was made on merits, the conviction of the accused was upheld in 6 (22%) cases. Four of these cases are appeals whereas 2 of them are revision petitions against the decisions of the lower courts.

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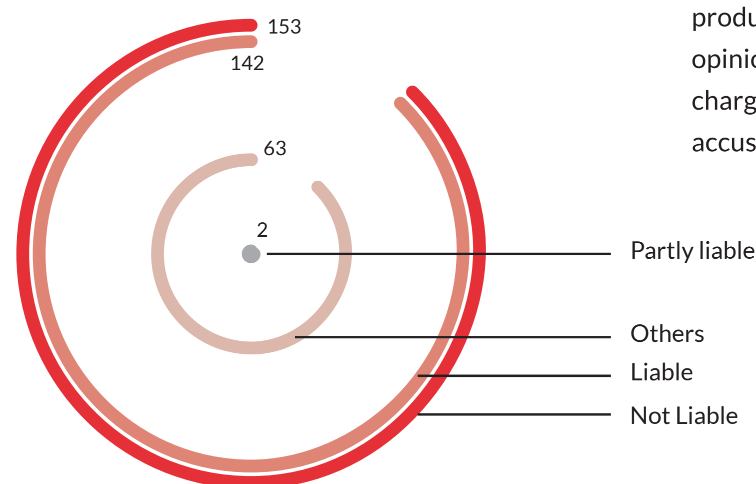
Table 2.2 Outcomes in High Court criminal cases decided on merits

Case Type in High Courts	Acquittal	Conviction
Criminal appeal	12	4
Criminal revision petition	5	2
Writ petition	1	0
Criminal misc. case	2	0
Public Interest Litigation	0	0
Regular second appeal	1	0
Grand Total	**21**	**6**

Even in the consumer courts, a majority of cases are decided in favour of healthcare professionals. However, the gap between cases where they are held liable and those where they are not is much narrower as compared to convictions and acquittals in criminal cases. As per our data, out of the 360 cases that we analysed, 153 cases were adjudicated in favour of healthcare providers, i.e., about 43% of the total cases. 142 cases (39%) were adjudicated in favour of the complainant, holding the healthcare professional liable.

Further, in 2 cases, the healthcare service providers were held 'partly liable' – the consumer commission accepted that there was a deficiency in service on the part of the healthcare provider but did not award any compensation as it did not find any substantive damage that was caused to the complainant due to such deficiency.[76] 3 cases were settled, and 51 cases were not decided on merits and involved procedural issues like limitation,[77] jurisdiction of consumer commissions,[78] consideration of expert opinion,[79] etc.

Fig. 2.2 Outcomes of medical negligence cases before consumer fora



Grounds for decisions

Criminal

As seen above, more criminal cases have the acquittal of healthcare professionals as their final outcome than conviction. An interesting trend to note in acquittal cases before the HC, is the reliance on *Jacob Mathew* or rather the mandatory requirement to fulfil the test laid down in *Jacob Mathew*. Out of 21 cases of acquittals, *Jacob Mathew* was cited in 19 (about 90%) judgments, as opposed to conviction cases where it has only been cited in 33% of cases (2 out of 6). In 4 such cases of acquittals, it was cited in the context of the burden of proof on the complainant to produce prima facie evidence in the form of a credible opinion given by a competent doctor to support the charge of rashness or negligence on the part of the accused doctor.[80] In other cases, *Jacob Mathew* or

[76] *Smt. Geetha v Prasad Scanning & X-ray Centre* CC/74/2011, District Consumer Disputes Redressal Commission, Chamrajnagar (4 July 2012) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=18%2F545%2FCC%2F74%2F2011&dtofhearing=2012-07-04> accessed 20 August 2023.
Sabiha Kouset v Srinivasa Nursing Home CC/06/186, District Consumer Disputes Redressal Commission, Mysore (18 January 2007) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=18%2F544%2FCC%2F06%2F186&dtofhearing=2007-01-18> accessed 20 August 2023.
[77] See for instance, *Shruthi C Borkar and Other v Panacea Hospital and Others* CC/18/1116, District Consumer Disputes Redressal Commission, Bangalore (22 September 2022) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=18%2F538%2FCC%2F18%2F1116&dtofhearing=2022-09-22> accessed 20 August 2023.
[78] *SB Gupta v Maharaja Agarsen Hospital* CC/865/2010, District Consumer Disputes Redressal Commission, New Delhi (21 August 2019) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=8%2F12%2FCC%2F865%2F2010&dtofhearing=2019-08-21> accessed 20 August 2023.
Dubisetty Padmavathi v Dr G Surendrarao, The Executive Director, Yashoda Group of Hospital FA/104/2011, State Consumer Disputes Redressal Commission, Andhra Pradesh (22 November 2012) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=16%2F0%2FFA%2F104%2F2011&dtofhearing=2012-11-22> accessed 20 August 2023.
[79] *Dr. Kanchan Kanti Garai v Sri Sukanta Misra* RP/75/2015, State Consumer Disputes Redressal Commission, West Bengal (18 March 2016) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=4%2F0%2FRP%2F75%2F2015&dtofhearing=2016-03-18> accessed 20 August 2023.
[80] *Syja v Chandramathi* MANU/KE/3069/2021; Jafar v State of Uttar Pradesh, MANU/UP/3479/2016; *Hukam Chand v State* MANU/DE/1783/2016; Joyen Kisku v The State of Jharkhand MANU/JH/0210/2013.

Bolam were cited to determine the standard of proof for establishing medical negligence or the degree of medical negligence. In acquittal cases, a medical opinion in favour of the healthcare professional or the lack of any medical opinion supporting the complainant were cited as grounds.

In district court cases of acquittals, the reliance on Jacob Mathew or expert medical opinion was much less as compared to the HC cases. The case was cited only in 10 cases of acquittal and in 1 case of conviction. Of the 75 cases of acquittals altogether (irrespective of whether they cited Jacob Mathew or not), 4 cases cited the lack of medical opinion and in 4 cases, the expert opinion supported the contention that there was no negligence on the part of the accused medical professional. Interestingly in 4 other cases, even though the independent expert/ board gave the opinion that there was negligence, the Court still decided in favour of the medical professional stating that the prosecution could not prove its case beyond reasonable doubt.

Unauthorised practice of medicine constitutes negligence

Interestingly, in criminal cases, most healthcare professionals convicted were found to be practising medicine in an unauthorised manner. In some cases, this became the primary reason for their conviction, whereas, in others, they were convicted under relevant laws criminalising the practice of medicine without due registration or qualifications, in addition to negligence under the IPC.

In 3 out of 5 cases of conviction from the district courts, the concerned healthcare professional was not registered, had no registered clinic, or was practising outside the area of expertise. For instance, in a district court case in Maharashtra, it was alleged that a severe reaction to a drug prescribed by the accused had resulted in the patient's death. It was found that the doctor had treated her despite not being a registered medical practitioner (RMP). The court held the accused liable under section 304A of the IPC for causing the death of a 14-year-old girl by treating her recklessly and negligently. The Court, however, noted that the most important aspect of the case was that the accused was knowingly practising medicine without registration and thus, the accused had intentionally caused the death.[81] In *State v Dr Vijay Pahwa*,[82] Calcutta's Metropolitan Magistrate convicted the medical professional under section 304A of the IPC for negligence and under section 7 of the West Bengal Clinical Establishments Act, 1950 for running a nursing home without a licence. In *Dr Bhagwat Dayal v State*,[83] a district court in Delhi found the medical professional negligent per se for practising outside his area of expertise. He was an Ayurvedic medicine degree holder but administered allopathic medicine negligently, leading to the patient's death.

A similar pattern was noticed in the HC cases. In 3 out of 6 HC cases that resulted in convictions, the healthcare professionals were treating patients without adequate qualifications or without being duly registered with the State Medical Council. For instance, in one case, the healthcare professional, in addition to getting convicted under section 33 of the Maharashtra Medical Practitioners Act, 1961 for practising without registration, was also convicted

[81] *State of Maharashtra v Sayyad Abdul Kadar*, Reg. Criminal Case no. 47/2002, Court of the 2nd Judicial Magistrate of First Class, Ambajogai, District- Beed.
[82] GR – 1998/2005 (TR 874/2014), Court of Metropolitan Magistrate, 20th Court, Calcutta.
[83] CA No. 109/2017, Court of Additional Sessions Judge-04 and Special Judge (NDPS): South-East District, Saket Courts, New Delhi.

under section 304A. The court held that "though the accused did not have a degree in Allopathy and though he was not a medical practitioner, he still injected the deceased". The court noted that the accused was under a statutory duty not to enter the field of any other system of medicine as he was not appropriately qualified.[84]

In *Ravinder Ram Chander Banshi v State of NCT of Delhi*[85] too, the appellant convicted had no degree to practise as a medical professional. Interestingly, in one case, the healthcare professional was convicted for cheating under section 420 of the IPC and under section 304 (culpable homicide not amounting to murder) "for causing death on account of surgical interference by an unskilled person". The court held that since the accused was not authorised to treat, it cannot be a case under 304A.[86]

Convictions beyond section 304A in High Courts

Since the e-Courts portal only allows section-specific case search, not free text search, the district court judgments we analysed are limited to those under section 304A, as explained earlier. However, since Manupatra enabled free text search for High Court cases, we observe that medical negligence is not confined to 304A but can also be covered by other offences under sections 337, 338 and 304. In one such case, the accused was charged and convicted for negligence under section 338 of the IPC for causing grievous hurt by a rash and negligent act.[87] This is because 304A can only be applied when a person dies due to negligence, whereas the patient in this case was left in a vegetative state due to negligence. In another case, the healthcare professional was convicted under section 314 (with the intention of causing miscarriage of a woman, causes her death) and 304 (culpable homicide not amounting to murder) of the IPC and Section 5(2) and 5(3) of the Medical Termination of Pregnancy Act, 1971 for terminating a pregnancy without being a registered medical professional, and at a place not approved as per the Act.[88]

Consumer

Overview of Grounds/Methods used to Determine Medical Negligence

In order to gain an overview of the jurisprudential approaches adopted by consumer fora when deciding cases of medical negligence, and the relative importance placed on different kinds of medicolegal evidence and legal principles in the course of adjudication, we conducted an initial review of a random sample of 30 cases. This review revealed certain common categories of medicolegal evidence and legal principles discussed by consumer fora in their judgments, which we then used to classify the cases in our database of 360 cases. The category of '*medicolegal evidence*' was used to cover specific types of evidence used to understand and interpret the facts of the case in the course of adjudication, i.e.:

a. expert opinion - this refers to cases in which the court discussed evidence / testimony from experts presented before it in respect of the medical concern at issue in the case,
b. opinion of a pre-existing or specially constituted expert medical board / committee - this refers to cases in which the medical aspects of the matter were referred to an expert medical board or committee, whether already in existence, or constituted specifically for the instant case, to ascertain the standard and / or negligent character of the treatment or care in a particular case, and
c. medical literature - this refers to scientific and medical academic materials and literature presented before, or sought out, by the court, in order to better understand the medical events in a given case.

The category of '*legal principles*' was used to cover:

a. established legal doctrine / principle - this refers to jurisprudential principles, outside of statutory provisions, being principles laid down via precedent or otherwise forming part of established legal theory, doctrine, or reasoning, and
b. case law - although this overlaps with the previous category, a separate category was created for cases that discuss precedent / case law.

About 22% of the total dataset (78 cases) were decided either on technical grounds (such as the law of limitation or jurisdictional limits) or on the basis of general legal principles that did not specifically pertain to the medical facts or medico-legal issues in contention in a given case. We will discuss the remaining 78% (287 cases)[89]. Out of this subset, we found that about 34% (98 cases) did not discuss any '*medicolegal evidence*' or '*legal principles*' at all, restricting themselves purely to the facts of the case to reach a decision. Interestingly, this rate was higher in cases involving the death of the patient – i.e. of the 13% (36 cases) – about half saw no '*medicolegal evidence*' or '*legal principles*' discussed. About 24% of cases (i.e. 69) did not discuss any 'medicolegal evidence' but discussed case law, while 3% (9 cases) considered only '*legal principles*' without citing any case law, or discussing '*medicolegal evidence*'. The figures for the different kinds of '*medicolegal evidence*' considered in cases involving death and in other cases, as mentioned by the consumer fora in their judgments, are set out in table 2.2. These figures pertain to cases decided based on substantive medicolegal issues, and do not include cases decided on procedural or other technicalities.

Table 2.2: Kinds of '*medicolegal evidence*' considered (*as mentioned by the consumer forum*) in cases involving death

Medico-legal evidence considered	Cases involving patient-death
None	37
Medical literature	13
Opinion of specially constituted medical board	6
Expert opinion, Medical literature	3
Opinion of existing medical board	2
Expert opinion + Opinion of existing medical board	1
Expert opinion + Ruling of SMC in the same matter	1
Order of MCI + Decision of Ethics Committee	1
Ruling of SMC in the same matter	1
Grand Total	**69**

[84] *Bhupal Malayya Agbattini v State of Maharashtra*, MANU/MH/0759/2019.
[85] *Ravinder Ram Chander Banshi v State of NCT of Delhi*, MANU/DE/2615/2014.
[86] *Sanat Kumar v The State of Bihar* Criminal Appeal (SJ) No. 1546 of 2017: MANU/BH/1247/2019.
[87] *Sanjay Mutha v Jayasree Desai* MANU/AP/0265/2007.
[88] *Riyazuddin v State NCT of Delhi* MANU/DE/3120/2014.

[89] A few cases overlap between both subsets, having been decided partly on technical grounds and partly on substantive grounds, and categorised accordingly during the analysis.

Table 2.3: Kinds of 'medicolegal evidence' considered (as mentioned by the consumer forum) in cases not involving death

Medico-legal evidence considered	Other Cases (not involving patient-death)
None	141
Medical literature	40
Expert opinion	17
Opinion of specially constituted medical board	9
Expert opinion + Medical literature	4
Miscellaneous	3
Opinion of existing medical board	2
Opinion of specially constituted medical board + Medical literature	1
Grand Total	**217**

Analysis of Adjudicatory Approaches of Consumer Fora

Our analysis suggests that consumer fora most commonly adopt three or four adjudicatory approaches when deciding a matter on its merits. These involve reviewing: (a) the facts themselves as presented before the forum, to lead the forum to a conclusion as to liability, applying the legal doctrine of res ipsa loquitur with or without specific reference to the maxim, (b) the opinions of experts as submitted to the forum by the litigants, (c) medical literature / scientific writings as submitted before the forum, or sought out by it, to shed light on technical aspects of the subject matter of the complaint before it, or to elucidate prevailing standards and best practices in the relevant field, (d) the reports or opinions issued by pre-existing or specially constituted expert medical boards, committees, or commissions evaluating the events and determining the fact of negligence in a particular case.

Some takeaways and peculiarities noted as part of our analysis of individual cases, are set out below:

a. Expert opinion and medical records

We have seen above that the decision of the court in the majority of cases has not involved consideration of expert evidence. However, it is worth noting that consumer fora frequently stipulate that expert medical opinion is a prerequisite when determining medical negligence, despite the Supreme Court's judgment in *V. Kishan Rao*, which held that expert opinion should not be a straightjacket formula to determine negligence in every case. While several judgments in our dataset specifically acknowledge the later precedent in *V. Kishan Rao*, and applied this when determining the need for expert opinion to elucidate the facts or scientific technicalities of a case, there is still heavy reliance on medical opinion, which was often one of the primary reasons for not holding the healthcare professional liable or for dismissing the complaint in a particular case.

Another ground was a failure on the part of the complainant to adduce sufficient evidence, apart from expert opinion, to prove the liability of the healthcare provider. Often, test reports are relied upon to determine if the healthcare professional took due care during treatment or diagnosis, though occasionally the completeness and correctness of the test reports and case sheets were themselves causes of action.[90] In one such case, the District Commission noted that while there was no expert opinion in the matter to prove the negligence of the concerned doctor, the affidavit of a nursing staff member who was present during the operation was sufficient to determine negligence and affix liability on the doctor.[91]

b. Invoking the doctrine of res ipsa loquitur

As seen above, the commissions also rely on the doctrine of *res ipsa loquitur* to determine negligence on the part of the doctor.[92] Even when the doctrine is not expressly invoked, the commissions determine the liability of the respondents from the facts themselves, especially when the negligence on the part of the doctor is particularly egregious. For instance, in one case, where the complainant had undergone surgery and skin grafting, the commission ruled that when a doctor fails to "diagnose a known complication of surgery i.e. (in this case the necrosis) even after frequent visits by the patient for review", it would amount to a deficiency in service.[93] In other cases, doctors have been held liable for deficiency of service when the complainant has had to correct their fracture in another hospital even after surgery

[90] See for instance, Lifina Jose/ *Anu Jose v Ozanam Eye Centre*, Bishop Benzigar Hospital CC/04/403, District Consumer Redressal Forum, Kollam (29 August 2009) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F561%2FCC%2F04%2F403&dtofhearing=2009-08-29> accessed 20 August 2023; Beenamol *KN v DCH Clinical & Pathological Laboratory* CC/35/2017, District Consumer Disputes Redressal Commission, Kottayam (31 May 2018) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F558%2FCC%2F35%2F2017&dtofhearing=2018-05-31> accessed 20 August 2023; *V P Raveendran v The Manager*, Saroj Diagnostic Laboratory CC/485/2015, District Consumer Disputes Redressal Commission, Kozhikode (26 September 2019) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F552%2FCC%2F485%2F2015&dtofhearing=2019-09-26> accessed 20 August 2023.

[91] *Mohammad Abbas v Dr Nishant Sethia* CC/11/2018, District Consumer Disputes Redressal Commission, Karnal (24 September 2009) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=9%2F79%2FCC%2F11%2F2018&dtofhearing=2019-09-24> accessed 20 August 2023.

[92] See, for instance, *Narasingh Pathi v Apollo Hospitals* CC/25/2004, State Consumer Dispute Redressal Commission, Tamil Nadu (14 June 2008) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=19%2F0%2FCC%2F25%2F2004&dtofhearing=2018-06-14> accessed 20 August 2023;
Dr Arup Dey v Sikha Dev A/21/2021, State Consumer Dispute Redressal Commission, West Bengal (25 August 2022) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=50%2F0%2FA%2F21%2F2021&dtofhearing=2022-08-25> accessed 20 August 2023;
Siddhartha Das v The Director/Manager/Head, Kolkata OPD SRL Ltd, India IVF Hospital Ltd CC/270/2020, District Consumer Dispute Redressal Commission, Kolkata Unit- II (Central) (15 September 2022) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=4%2F623%2FCC%2F270%2F2020&dtofhearing=2022-09-15> accessed 20 August 2023;
Rita Varmani v Woodstock Nursing Home FA/772/2006, National Consumer Dispute Redressal Commission (19 July 2011) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=0%2F0%2FFA%2F772%2F2006&dtofhearing=2011-07-19> accessed 20 August 2023;
Tilak Raj v Shah Hospital CC/82/18, District Consumer Dispute Redressal Commission, Kaithal (1 February 2021) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=9%2F78%2F82%2F18&dtofhearing=2021-02-01> accessed 20 August 2023;
Deepak Kumar v Mahesh Mahajan Multi Speciality Hospital and Trauma Centre CC/430/2015, District Consumer Dispute Redressal Commission (8 December 2016) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=12%2F43%2FCC%2F430%2F2015&dtofhearing=2016-12-08> accessed 20 August 2023.

[93] *Abdul Majeed v Malliya City Hospital* CC/118/2005, District Consumer Dispute Redressal Commission, Kasaragod (31 May 2011) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F549%2FOP+No.118%2F2005&dtofhearing=2011-05-31> accessed 20 August 2023.

by the appellant doctor,[94] and when the complainant patient was released from the hospital on personal risk bond and admitted in a nursing home under the same doctor under the false pretence of receiving better treatment.[95]

c. Existence and Degree of Damage / injury as determinants of liability / compensation

Commissions have held contradictory things when it comes to determining the degree of actual injury / damage that occurred due to the alleged act of the respondent(s) and warranting compensation. In one case, the complainant and his wife alleged medical negligence on the ground that the doctor gave a wrong diagnosis about the heart of the foetus, which caused them mental agony and forced them to go the next day for a second opinion, which affirmed that the pregnancy had no complications.[96] The District Commission held that though the complainant and his wife suffered for one day, the extent of suffering was sufficient to cause mental agony and awarded compensation.

On the other hand, the doctor in a case failed to detect physical deformities in the foetus during the pregnancy and had informed the complainants that the foetus was healthy. However, the child was born without properly developed fingers.[97] The District Commission relied on *Kusum Sharma* to point out that negligence becomes actionable on account of *injury* resulting from the act or omission amounting to negligence attributable to the person sued. In this case, the Commission stated that although the doctor was liable for deficiency in service in not conducting tests properly, there was no damage. This is because there was "no medication for the growth of bone and further the complainant could not have gone for medical termination of pregnancy and the law does not have [sic] permit for the same for missing fingers in the left hand." Consequently, no compensation was awarded.

In yet another case, the complainant was assured that the foetus was in good health but the foetus instead suffered an intrauterine demise.[98] Additionally, the stillborn child had several physical deformities which were visible during scans but were not revealed to the complainant. The District Commission held that even though the doctor was liable for deficiency in service, it could not assume that the complainant would have opted for medical termination of pregnancy had she been informed about the foetus' physical deformities. It only awarded the compensation of Rs. 5000 noting that "if the complainant had given birth to the baby with the anomalies then the quantum of compensation would have been much higher as negligence would also have counted".

[94] *Dr. S.S. Ravikumar, Arunkumar Hospital v Thirupathi* FA/341/2011, State Consumer Dispute Redressal Commission, Tamil Nadu (10 December 2021) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=19%2F0%2FFA%2F341%2F2011&dtofhearing=2021-12-10> accessed 20 August 2023.
However, in another case, it was held that "simply because someone has to be further treated in the hospital after being treated by the doctor in an earlier hospital, does not ipso facto prove the point that the doctor had committed any negligence in treating the patient": See Dr Ritika Mathur v Gudiya Tiwari A/2006/2801, State Consumer Dispute Redressal Commission, Uttar Pradesh (2 May 2017) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=14%2F0%2FA%2F2006%2F2801&dtofhearing=2017-05-02> accessed 20 August 2023.

[95] *Dr Supriya Malthy v Basudev Maitra* A/856/2017, State Consumer Dispute Redressal Commission, West Bengal (24 October 2019) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=4%2F0%2FA%2F856%2F2017&dtofhearing=2019-10-24 > accessed 20 August 2023.

[96] *Dokku Bhikshapathi v Dr Pallavi Kathare* CC/514/2015, Consumer Dispute Redressal Commission, Hyderabad (21 January 2019) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=43%2F500%2FCC%2F514%2F2015&dtofhearing=2019-01-21>accessed 20 August 2023.

[97] *Smt. Geetha v Prasad Scanning & X-ray Centre* CC/74/2011, District Consumer Disputes Redressal Commission, Chamrajnagar (4 July 2012) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=18%2F545%2FCC%2F74%2F2011&dtofhearing=2012-07-04>accessed 20 August 2023.

[98] *Sabiha Kouset v Srinivasa Nursing Home* CC/06/186, District Consumer Disputes Redressal Commission (18 January 2007) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=18%2F544%2FCC%2F06%2F186&dtofhearing=2007-01-18>accessed 20 August 2023.

In the two cases above, it is interesting to note that the complainants appear to have been viewed as passive patients who could or would not have chosen to medically terminate the pregnancy. The failure on the part of medical professionals to provide sufficient information to the patient in order to make an informed choice was not viewed as a deficiency in service by the Commissions.

How far is the Court's reasoning justified?

a. Different standard of proof to prosecute medical professionals

The criminal law imposes a high burden of proof, more onerous than that of a plaintiff in a civil suit or a complainant under consumer protection law. The standard of 'beyond reasonable doubt' has been turned on its head in consumer cases. For instance, in one consumer case, the district consumer commission ruled that once the complainant has prima facie proven the liability of the respondent doctor, the respondent has to then prove 'beyond reasonable doubt' that they had taken due care and caution during the treatment or diagnosis.[99]

On the other hand, in criminal cases of medical negligence, the already-high burden for prosecution becomes even higher. Medical professionals have unique protections under the criminal negligence law, beyond the protections they generally enjoy in their status as a person accused of a crime. This can be attributed to *Jacob Mathew*, which reflects how courts think about the impact of criminal convictions on the status of a person in society.

In this case, the court stated that "[t]he criminal law has invariably placed medical professionals on a pedestal different from ordinary mortals." In other words, the criminal law of negligence is applied differently to doctors than everyone else.[100] The reason for this is that the courts recognise that qualified medical professionals perform a scarce social function. Therefore, "'indiscriminately prosecuting them does not serve society".[101] The court stated that "all that we are doing is to emphasise the need for care and caution in the interest of society; for, the service which the medical profession renders to human beings is probably the noblest of all, and hence, there is a need for protecting doctors from frivolous or unjust prosecutions."

b. Moving away from the Bolam test

The court in *Jacob Mathew*, following *Bolam*, placed excessive reliance on medical opinion as primary evidence. This needs to be revisited in light of judicial and scholarly developments globally in a direction away from *Bolam*.[102] It places a higher burden of proof on the complainant, and the lack of such proof then results in the dismissal of complaints or acquittals. However, as a defence for healthcare professionals, this requirement is met merely by getting medical professionals who would testify that they would have done the same as the defendant did. This is because of the reasonable doctor test laid down by *Bolam*, which holds that as long as a doctor's actions are consistent with what a reasonable doctor would have done in a similar situation, they cannot be held accountable for either performing or failing to perform a particular act.

[99] *Shamsudeen v Dr Shajahan Yoosuf* CC/10/313, District Consumer Dispute Redressal Commission, Ernakulam (30 June 2012) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F556%2FCC%2F10%2F313&dtofhearing=2012-06-30> accessed 20 August 2023.

[100] The matter did not end there. The referring bench (two judges) in *Jacob Mathew* doubted the correctness of the decision in *Dr Suresh Gupta*, and so referred it to a larger bench. Ultimately, in Jacob Mathew, the Supreme Court upheld the distinction.

[101] *Jacob Mathew* (n 8) 28.

[102] Margaret Brazier and José Miola, 'Bye-bye *Bolam*: a medical litigation revolution?' (2000) 8 Medical Law Review 85.

There has been a significant judicial transition in the UK since *Bolam*. In *Bolitho*, it was held that the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are of the genuine opinion that the defendant's treatment or diagnosis accorded with sound medical practice." *Bolitho* emphasised that any standard must have a logical basis and a thorough evaluation of the potential advantages and disadvantages of alternative options. *Bolam's* requirements were further blurred by the UK Supreme Court's landmark judgment in *Montgomery v Lanarkshire Health Board*,[103] which rejected the reasonable doctor test and took a more patient-centric approach.

c. Barriers presented by Jacob Mathew and Bolam

The Indian Supreme Court too, in *V. Kishan Rao*,[104] criticised *Bolam* and took a different view than *Jacob Mathew* by holding that an expert opinion need not be sought in all cases, especially, consumer cases where the objective is to ensure timely justice. It further stated, "(the) time has come for this court also to reconsider the parameters set down in *Bolam* test as a guide to decide cases on medical negligence and especially in view of Article 21 of our Constitution which encompasses within its guarantee, a right to medical treatment and medical care."

Despite these developments, Indian courts continue to follow *Bolam* and rely on peers' opinions as the gold standard for determining medical negligence. There are two major issues as far as the current judicial position in India with respect to medical negligence is concerned. First, the peers' opinions sought may not always be reliable evidence--medical professionals may not be willing to speak up against their colleagues. As the Supreme Court noted in *Martin D'Souza*, "Judges have usually to rely on testimonies of other doctors which may not necessarily in all cases be objective, since like in all professions and services, doctors too sometimes have a tendency to support their own colleagues who are charged with medical negligence".

Secondly, the inflexible requirement to adhere to the guidelines laid down in *Jacob Mathew* has proved to be an obstacle in the timely delivery of justice, especially, when other evidence is conclusive of medical negligence. This was particularly observed in *Kamaljeet Singh v Prem Lal*,[105] where the Punjab & Haryana High Court noted that in view of the mandate of Article 141 of the Constitution, it was bound to follow the precondition of seeking medical opinion laid down in *Jacob Mathew* despite having conclusive evidence otherwise to determine medical negligence.

The guidelines laid down in *Jacob Mathew* were meant to be implemented only temporarily until the Government of India and/or the State Governments issue statutory rules or executive instructions/ guidelines. While the Government of India has not taken any steps so far, several State Governments have issued guidelines in this regard including Odisha, Tripura, Uttar Pradesh, Jammu and Kashmir, and Rajasthan. Except for Odisha and Tripura, where guidelines were issued in 2012 and 2014 respectively, all other states have issued guidelines between 2019 and 2022. However, they are essentially reiterations of what was laid down in *Jacob Mathew*. Punjab and Haryana are outliers as they issued notifications in 2017 setting up District level medical boards consisting of specialists/experts to ascertain the alleged negligence/criminal negligence of doctors. Haryana's notification, however, specifically mentions that the medical board is being set up to examine complaints of medical negligence and to "ensure the application of *Bolam's* test."

[103] (2015) UKSC 11.
[104] *V. Kishan Rao v Nikhil Super Speciality Hospital* MANU/SC/0332/2010.
[105] *Robin Masih v State of Punjab*, MANU/PH/1337/2019.

D. Who is held accountable

The National Health Profile, 2022 reported that there are 60,621 government hospitals in rural and urban India.[106] There are no similar publicly available official statistics on the number of private hospitals operating in India. The National Sample Survey, 2019 merely indicates that health infrastructure in India is predominantly supported by the private sector with about 66% of all treatment being provided by it.[107] It further reported that both urban and rural populations prefer getting treatment in private hospitals despite the fact that they cost 151% more than government hospitals.[108] There are, of course, regional variations. While the public health sector is crippled by the stark shortage of qualified professionals,[109] the stressed private health sector has also been known to struggle with delivering quality care while booking high profits.[110]

Given this background, we wanted to understand if this public/private dichotomy is reflected in the litigation landscape of the country, and if so, how? Therefore, while reading the judgments, we decided to capture the details of whether the healthcare provider was a private entity or a government entity wherever it could directly be ascertained from the text of the judgment itself. We also noted whether the healthcare provider was an individual (including one or more doctors, nurses, compounders etc.) or an establishment (including hospitals, diagnostic centres, nursing homes etc.).

Table 2.4 Categories of parties accused of medical negligence across the dataset

	District and Consumer Fora		High Court		
Type of Accused Healthcare Provider	Trial Court	Consumer	High Court - Criminal	High Court -Consumer	Total
Government Establishment	0	8	1	2	11
Government Individuals	16	5	36	1	58
Government Individuals + Government Establishments	0	13	4	0	17
Private Establishment	0	65	9	1	75
Private Individuals	59	83	93	1	236
Private Individuals + Private Establishment	3	96	8	1	108
Unclear	2	90	75	7	174
Total	**80**	**360**	**226**	**13**	**679**

[106] Central Bureau of Health Intelligence, *National Health Profile* 2022 (2022) 405 <https://cbhidghs.nic.in/WriteReadData/l892s/94203846761680514146.pdf > accessed 06 May 2023.
[107] Ministry of Statistics & Programme Implementation, *Key Indicators of Social Consumption in India*: Health, 75th Round of National Sample Survey (2019) 19 <https://www.mospi.gov.in/sites/default/files/publication_reports/KI_Health_75th_Final.pdf> accessed 6 May 2023.
[108] ibid 26.
[109] Divyani Dubey, 'How True Is the Health Minister's Claim That India's Doctor-Population Ratio Exceeds WHO Guidelines?' (*Scroll.in*, 5 August 2022) <https://scroll.in/article/1029766/how-true-is-the-health-ministers-claim-that-indias-doctor-population-ratio-exceeds-who-guidelines> accessed 21 May 2023; Sarit Kumar Rout, Kirti Sundar Sahu and Sandeep Mahapatra, 'Utilization of Health Care Services in Public and Private Healthcare in India: Causes and Determinants' (2021) 14 International Journal of Healthcare Management 509 <https://www.tandfonline.com/doi/abs/10.1080/20479700.2019.1665882> accessed 21 May 2023.
[110] 'Many Indian Doctors under Pressure to Meet Revenue Targets' *Economic Times* (4 September 2015) <https://economictimes.indiatimes.com/nri/working-abroad/many-indian-doctors-under-pressure-to-meet-revenue-targets/articleshow/48807934.cms> accessed 21 May 2023.

We observe that the majority of criminal complaints have been filed against individual medical practitioners. In contrast, in the majority of consumer cases, a complaint is filed against both the establishments and the individual doctors who practise in these establishments. More complaints are filed against private healthcare providers in both types of cases. This is probably explained by the predominance of the private sector in India and the non-applicability (for the most part) of the Consumer Protection Laws to public healthcare establishments where there is no consideration for services. Further, in a few criminal cases before the High Courts, there are instances where the state is also added as a party to the cases. These include cases where the court has given directions to the government to take action against unauthorised hair transplant clinics in the state,[111] or directions to the investigating officer to act neutrally, include expert opinion in their final report, visit the site of investigation, or monitor the investigation appropriately.[112]

In the section below, we look at some of the legal principles which deter certain forms of complaints.

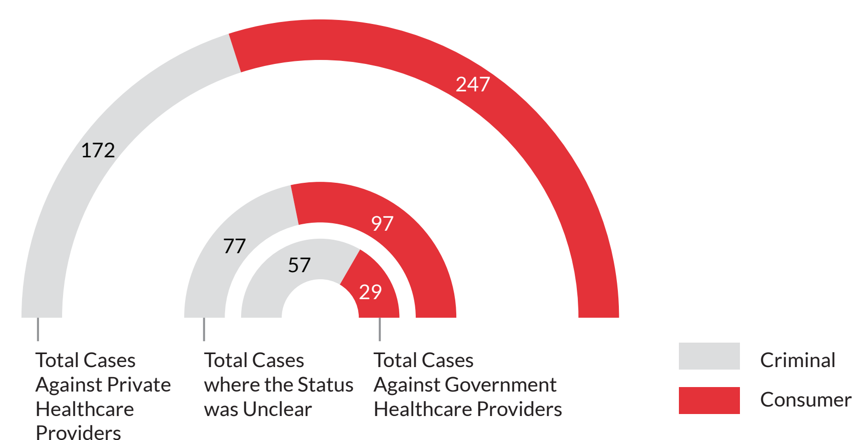
Barriers to prosecuting government healthcare providers

It is possible that the procedure for prosecuting a government doctor deters the victim from approaching the courts with criminal complaints. When a doctor is engaged by the government, s/he is considered a public servant discharging official duty. Under section 197 of the CrPC, a court cannot take cognizance of an offence committed by a public servant except with the previous sanction of the competent authority.[113] Failure to obtain such a sanction can be a ground for quashing proceedings against the doctor. We found similar cases in our dataset where the High Court quashed proceedings instituted against government doctors without obtaining a sanction.[114] However, if a government doctor receives a bribe or illegal gratification, then the courts found that no prior sanction is required to prosecute them as this would not amount to an act done in the official discharge of duty but would instead be considered as an act done in the colour of such duty.[115] Thus, the court has to consider the facts and circumstances of the case to determine whether there is a nexus between the alleged offence and the discharge of duty by the doctor as a public servant.[116]

As with criminal cases, it is more common for a private healthcare provider to be the opposing party in consumer cases as well. This is not surprising given the ratio in *VP Shantha* where it was held that a government hospital providing services free of charge would not be covered under the Consumer Protection Acts. For the legislation to apply to a government hospital, it would have to be proved that patients paid at least some amount for the services at the hospital. The consumer fora have repeatedly noted that whether the patient could be considered a 'consumer' under the Acts depended on the facts and circumstances of the respective case. For instance, in one case the patient paid Rs. 1,050 towards room charges for seven days and Rs. 30 each for anaesthesia and operation theatre at the time of her delivery. However, no amount was charged for medicines or doctor fees. The district forum in this case held that the patient did not qualify to be a consumer under the Act as the amount paid was too meagre to meet the expenses of the operation theatre and therefore dismissed the complaint which alleged that the tubectomy had been performed without obtaining the patient's consent.[117] Similarly, the NCDRC has held that only payment of registration charges cannot be considered as a significant amount paid by the patient and the Act would not apply in such a case.[118] Thus, in almost all cases where it was argued that the patient had received free services, the consumer fora dismissed the complaint in accordance with the decision in *VP Shantha*.[119]

In our dataset, we found only 8 cases where a government hospital or doctor was found to be liable under the Consumer Protection Acts. In 2 of these cases, the government hospital took the defence that services were rendered to the patient free of charge and thus they could not be considered to be 'consumers' under the Act. However, the consumer fora in these cases relied on *VP Shantha* to hold that since the said hospital provided services on payment to some patients, the Act would apply irrespective of the fact that the service is rendered free of charge to persons who do not pay such service.[120]

Fig. 2.3 Number of medical negligence cases across the dataset involving government and private healthcare providers



[111] See for instance, *Azhar Rasheed v State NCT of Delhi* MANU/DE/1679/2022.
[112] See for instance, *S Mahaveer Shivaji v State* MANU/TN/0789/2013; *The Inspector of Police v S Manimuthu*, W.A. (MD) No. 426 of 2020 and C.M.P. No. 2934 of 2020: MANU/TN/1448/2021.
[113] See *Manorama Tiwari v Surendra R* MANU/SC/1005/2015; *Devinder Singh v State of Punjab*, MANU/SC/0450/2016; *State of Maharashtra v Mahesh G Jain* MANU/SC/0561/2013.
[114] See for instance, *Kusum v Prabhavati* MANU/MP/0628/2013; *Mohd. Kasim Ali v State* MANU/KA/0407/2019; *Manish Bansal v State of Haryana* MANU/PH/0128/2019; *Ramesh Kumar Madhok v State of Rajasthan* MANU/RH/1556/2017.
[115] *Shivanand Doddamani v State of Karnataka* Criminal Petition No. 7203 and 7219 of 2010: MANU/KA/0779/2010.
[116] *Mohd. Kasim Ali v State Criminal Petition* No. 200548/2018(Karnataka High Court): MANU/KA/0407/2019.
[117] *Bushra v Lok Nayak Hospital* CC/69/2014, Consumer Dispute Redressal Forum, North Delhi (25 March 2015) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=8%2F9%2FCC%2F69%2F2014&dtofhearing=2015-03-14> accessed 20 August 2023.
[118] *BSF Composite Hospital v Sukhi Ram* RP/616/2019, NCDRC (30 September 2022) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=0%2F0%2FRP%2F616%2F2019&dtofhearing=2022-09-30> accessed 20 August 2023.
[119] See for instance, *Ajmal.K.P v Dr Greeshma* CC/67/2022, Consumer Dispute Redressal Forum, Kannur (24 November 2022) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F550%2FCC%2F67%2F2022&dtofhearing=2022-11-24> accessed 20 August 2023; *Smt. Rajani v Dr Anasuya Rajeev* CC/46/2016, Consumer Dispute Redressal Forum, Alappuzha (30 December 2015) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F559%2FCC%2F46%2F2016&dtofhearing=2017-12-30> accessed 20 August 2023; *Renu Kumari v Acharya Shree Bhikshu Govt Hospital* CC/22/88, Consumer Dispute Redressal Forum, West Delhi (16 March 2022) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=8%2F4%2FCC%2F22%2F88&dtofhearing=2022-03-16> accessed 20 August 2023; Pinki Bibi v Block Medical Officer of Health CC/102/2014, Consumer Dispute Redressal Forum, Murshidabadi (31 August 2022) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=4%2F313%2FCC%2F102%2F2014&dtofhearing=2022-08-31> accessed 20 August 2023.
[120] *Balaka Ghosh v Superintendent*, Seth Sukhlal Karnani Memorial Hospital RBT/CC/146/2017, District Consumer Dispute Redressal Forum, Kolkata Unit - II (Central) (06 March 2019) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=4%2F623%2FRBT%2FCC%2F146%2F2017&dtofhearing=2019-03-06> accessed 20 August 2023; *Bishnu Chakraborty v Dr Tapan Mandal* CC/2/2018, West Bengal State Consumer Disputes Redressal Commission, Asansol Circuit Bench (15 June 2022) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=49%2F0%2FCC%2F2%2F2018&dtofhearing=2022-06-15> accessed 20 August 2023.

Complaints were also filed against government hospitals for failing to ensure that the beneficiaries of government health schemes received proper treatment. We found two such cases. In the first one, the Employee State Insurance Corporation (ESIC) hospital, after conducting the diagnosis, observed that it did not have the proper arrangements to treat the patient. Despite this, they did not refer the patient to a super-speciality hospital with which they had a tie-up. The NCDRC found the hospital to be deficient in rendering services in this case on account of the suffering that the patient had to undergo.[121] In another case, the complainant was a beneficiary of the Ex-Servicemen Contributory Health Scheme (ECHS).[122] As a beneficiary, the patient was entitled to free treatment at the private hospital. However, the hospital charged the patient and refused to reimburse the bill. In this case, the district forum found the officer of ECHS Polyclinic to be deficient in service for failing to take action against the erring hospital and assisting the patient in receiving reimbursement.

The remaining 4 cases were regular cases of medical negligence, similar to the ones we see being instituted against private healthcare providers.

Pinning criminal liability on establishments

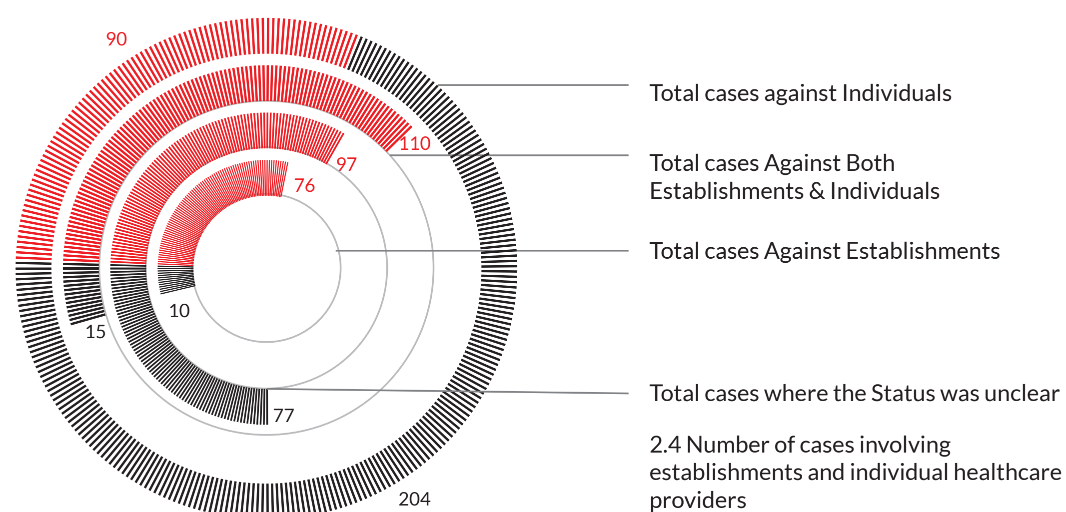
It is difficult to attribute criminal medical negligence to an establishment such as a hospital or a nursing home. This is simply because these establishments are incapable of committing offences requiring mens rea, that is, a guilty mind. Medical care is primarily dependent on the individual skill and knowledge of the attending doctor and as such, any breach in duty is directly attributable to the doctor. This also appears to be the understanding adopted by the courts. In one of the judgments, the Delhi High Court observed that 'the offence of criminal negligence requires a specific state of mind in respect of the person committing the offence. The offence of medical criminal negligence cannot be fastened on the company since the company can neither treat nor operate a patient of its own', and thus the criminal liability would fall on the doctor rather than the hospital.[123]

It further observed that '(h)owever, if there is an administrative negligence, or a negligence of not providing basic infrastructure, which results into some harm to an aggrieved person or such negligence which is impersonal, the hospital can be held liable.'[124] This view was reiterated by the Delhi High Court in its later judgment where the director of a hospital was summoned for being vicariously liable for the offence under section 336 of the IPC.[125] In a recent case, a trial court convicted a hospital of criminal negligence under 304A despite the fact that a plea was raised on the ground that the hospital lacks the specific state of mind required to commit the offence and it cannot on its own treat the patient. On appeal, the district court found that the hospital had failed in its duty to provide quality care to the patient by failing to deploy qualified doctors and providing the requisite facilities.[126] Observing that criminal negligence could be attributed to the hospital if certain administrative lacunae are found adding to the reason for the death of a patient, the court upheld the sentence of Rs. 10 lakhs to be paid by the hospital.

It is interesting to note that as opposed to criminal cases, in most cases before the consumer fora, both the establishment and the individual doctors are made the respondents. It must be remembered that no *mens rea* is required to be attributed to the wrongdoer to establish civil liability. Therefore, attributing individual responsibility for the wrong is not necessary. Further, a lower degree of negligence is needed to be proven before consumer fora, making them more amenable to holding healthcare establishments accountable to patients.

Establishments such as hospitals or nursing homes can be made liable directly for institutional deficiencies of services or unfair trade practices. These include wrongs such as overcharging, false advertisement and failure to provide competent staff in addition to medical negligence in treatment. Further, establishments can also be held liable vicariously for the actions of their employees or contractual staff.[127] For instance, the NCDRC in *Post Graduate Institute of Medical Education and Research v Jasmine*[128] held the establishment vicariously liable for the negligent acts of its doctors. However, it gave the establishment the option to conduct their internal disciplinary proceedings and recover the amount from the erring doctors. The fora apply the reasoning that the hospitals, as masters of the people they contract for services, are responsible for their failure to ensure proper care of the patient.[129] Therefore, in a majority of cases, we find that both the establishment and the individual doctors are found liable in consumer cases.

Fig. 2.4 Number of medical negligence cases across the dataset involving establishments and individual healthcare providers

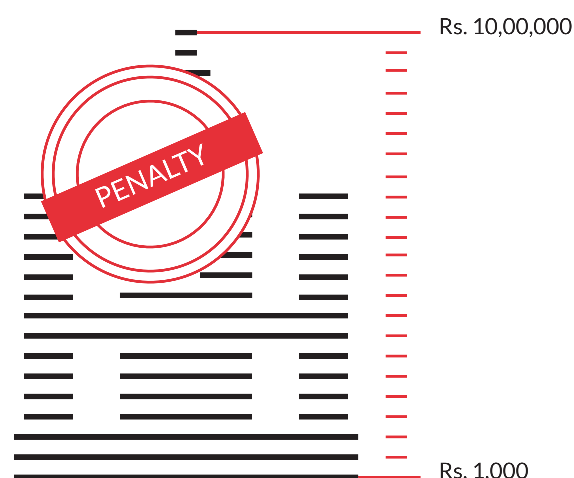


[121] *A Nageswara Rao v ESI Hospital* Revision Petition No. 61 of 2010, National Consumer Disputes Redressal Commission (06 October 2016) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=0%2F0%2FRP%2F61%2F2010&dtofhearing=2016-10-06> accessed 20 August 2023.
[122] *Chandrikha v Dr M Ramakrishnan* CC/182/2015, District Consumer Dispute Redressal Forum, Palakkad (16 November 2021) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F554%2FCC%2F182%2F2015&dtofhearing=2021-11-16> accessed 20 August 2023.

[123] *Indraprastha Medical Corp Ltd v State NCT of Delhi* MANU/DE/1995/2010.
[124] ibid.
[125] Act endangering life or personal safety of others.
[126] *Sunderlal Jain Hospital v State* CA No. 3/17 (03 March 2022) North West District, Rohini Courts Delhi.
[127] See for instance, *Vijay Kumar v Dr. Sonia Malik* CC/11/9, State Commission, Delhi (22 January 2019) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=8%2F0%2FCC%2F11%2F9&dtofhearing=2019-01-15> accessed 20 August 2023; *Smt. Asha v Udhbhava Hospital* CC/1734/2017, District Consumer Disputes Redressal Forum, Bangalore 1st & Rural Additional (17 December 2019) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=18%2F539%2FCC%2F1734%2F2017&dtofhearing=2019-12-17> accessed 20 August 2023.
[128] First Appeal No. 45 of 2012 (23 February 2018).
[129] *Shri Debashis Goswami v Dr. Soumitra Kumar* CC/131/2011, State Commission, West Bengal (10 August 2018) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=4%2F0%2FCC%2F131%2F2011&dtofhearing=2018-08-10> accessed 20 August 2023; INSCOL *Hospital v Inderjit Arora* RP/323/2011, National Consumer Disputes Redressal Commission (10 April 2017) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=0%2F0%2FRP%2F323%2F2011&dtofhearing=2017-04-10> accessed 20 August 2023; Lifina Jose/*Anu Jose, v Ozanam Eye Centre* CC/04/403, District Consumer Disputes Redressal Forum, Kollam (29 August 2009) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F561%2FCC%2F04%2F403&dtofhearing=2009-08-29> accessed 20 August 2023; *Chandrika v Dr Anil* CC/08/63, District Consumer Disputes Redressal Forum, Kozhikode (3 February 2017) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F552%2FCC%2F08%2F63&dtofhearing=2017-02-03> accessed 20 August 2023.

E. What kinds of remedies and punishments do courts award?

When the court in *Jacob Mathew* distinguished between criminal and civil standards for medical negligence, it offered a telling rationale: negligence performs different functions in civil and criminal law, i.e., while compensation in civil law is awarded as per the damages claimed and the injury proven, the sentence under criminal law is determined by the degree of negligence and/or mens rea. This section elaborates on remedies granted by courts in the form of compensation, sentencing and imposition of fines under consumer law and criminal law.



Criminal

The underlying objective of the criminal justice system is that the punishment given should be proportionate to the seriousness of the offence. If the appropriate sentence falls within the maximum sentence allowed by law, then the courts have the discretion to determine the specific sentence to be given. [130] As Sen and Sakshi (2017) note, "[T]he text of the law has little to provide in terms of deliberation on the nature and choice of punishments".[131]

Imprisonment and fines

Section 304A of the IPC prescribes a maximum of two years imprisonment along with fine. The text of the provision does not set any upper limit on the amount of fine that may be imposed, and courts have ordered a wide range of fines even within the limited number of relevant cases we observed. In our dataset of district court cases under section 304A, we found 5 cases, where the defendant healthcare service provider (individual doctor/hospital/State) was convicted and a fine was imposed or compensation was awarded. Amongst the 5 district court cases, the lowest fine imposed was Rs 1000 (in addition to 2 years of rigorous imprisonment)[132] and the highest was Rs 10,00,000, which was imposed on a hospital as opposed to an individual doctor.[133]

> Amongst the 5 district court cases, the lowest fine imposed was Rs 1000 (in addition to 2 years of rigorous imprisonment) and the highest was Rs 10,00,000, which was imposed on a hospital as opposed to an individual doctor.

[130] Srijoni Sen and Sakshi, 'Making the Punishment Fit the Crime: How Do Lawmakers Decide?' (2017) 52(8) Economic and Political Weekly <https://www.epw.in/journal/2017/8/commentary/making-punishment-fit-crime.html> accessed 2 September 2023.
[131] ibid.
[132] *Sanjay Mutha* (n 87).
[133] *Sunderlal Jain Hospital v State* CA No. 3/17, Court of Additional Sessions Judge-03, North West District, Rohini Courts, Delhi.

Table 2.5 Sentences awarded and fines imposed by district courts in criminal cases filed under Section 304A, IPC

Case	Brief facts of the case	Effective Imprisonment	Fine
Sunderlal Jain Hospital v State[134]	The cardiac care unit of the hospital had inadequate infrastructure and did not have specialists. This resulted in the patient succumbing to his injuries.		10,00,000 [to be paid by the hospital]
Bhagwat Dayal v State[135]	The accused practised Ayurveda and was not qualified to practise allopathic medicine. He administered the wrong injection during the treatment which caused complications and the patient died.	2 years RI	25000
State of Telangana v Dr Boora Srinivas[136]	The patient died due to septic shock after the accused improperly administered injections.	2 years RI	10000
State v Dr Vijay Pawha[137]	The accused doctor was running a nursing home without licence. Due to his negligence, the patient died during the cataract operation.	1 year SI*	5000
State of Maharashtra v Sayyad Abdul Kadar[138]	The accused was not a registered medical practitioner but had treated the victim. The patient died due to the negligence shown by the accused when treating her.	2 years RI	1000

** - in this case, the doctor was convicted under both Section 304A IPC as well as Section 7(a) WB CEA 1950. Since the sentences imposed under both these legislations were ordered to run concurrently, we have considered the higher term imposed under 304A as the effective imprisonment term for analysis.*

On the other hand, as discussed previously, our High Court cases are not limited to section 304A alone but cover criminal negligence under other sections of the IPC. In particular, healthcare professionals are convicted under sections 34, 314, 304, 338 and 304 in addition to section 304A. Consequently, in our dataset, significant variations can be observed in imprisonment terms and fines across High Court conviction cases and across different provisions of the IPC.

As observed in our dataset, the smallest sum imposed by High Courts was Rs 2000,[139] and the largest sum was Rs 5 lakhs, which was to be paid by the State as compensation.[140] In the latter case, a writ petition had been filed seeking the reopening of a police investigation regarding the accused doctor and awarding of compensation. The court declined to order the investigation to be reopened but directed the State to pay Rs. 5,00,000 as compensation to the victim.[141]

> The smallest sum imposed by High Courts was Rs 2000, and the largest sum was Rs 5 lakhs, which was to be paid by the State as compensation.

[134] CA No. 3/17, Court of Additional Sessions Judge-03, North West District, Rohini Courts, Delhi.
[135] CA No. 109/2017, Court of Additional Sessions Judge-04 and Special Judge (NDPS): South-East District, Saket Courts, New Delhi.
[136] CC No. 1542/2014, Court of Judicial Magistrate of First Class, Bellampalli.
[137] GR – 1998/2005 (TR 874/2014), Court of Metropolitan Magistrate, 20th Court, Calcutta.
[138] Reg. Criminal Case No. 47/2002, Court of the 2nd Judicial Magistrate of First Class, Ambajogai, District- Beed.
[139] *Sanjay Mutha* (n 87).
[140] *T Sulochana v Inspector of Police* MANU/TN/3342/2014.
[141] ibid.

Table 2.6 Sentences and fines imposed by High Courts in criminal medical negligence cases

Case	Provisions	Effective Imprisonment	Fine
Sanjay Mutha v Jayashree Desai[142]	338 IPC	3 months SI	2000
Ravinder Ram Chander Banshi v State of NCT of Delhi[143]	304 IPC	4 years RI	5000
Sanat Kumar v State of Bihar[144]	304 IPC, 420 IPC	7 years RI	35000
Riyazuddin v State NCT of Delhi[145]	314/34 IPC, 5(2) and 5(3) MTP	5 years RI*	1,05,000
Bhupal Malayya Agbattini v State of Maharashtra[146]	304A IPC, 33 MMPA [Maharashtra Medical Practitioners Act 1961]	2 years RI	1,53,000
Vasumathy v State of Kerala[147]	304A IPC	1 day	3,00,000
T . Sulochana v Inspector of Police[148]			500000 [to be paid by the State as compensation]

** - In this case, the accused was sentenced to 5 years RI under IPC, and 3 years RI each under two sections of MTP Act. For the purpose of our analysis, all three sentences are taken to be concurrent to each other.*

The shortest sentence for imprisonment was one day,[149] and the longest was 7 years of rigorous imprisonment.[150] Out of these 6 cases where an individual doctor was convicted, the accused was sentenced to concurrent imprisonment in 3 cases.[151]

Compensation in Criminal Cases

As discussed previously, one of the primary objectives of criminal law is to deter the accused. However, interestingly, courts have also stepped in to award compensation to the victims for loss or injury in criminal cases. Section 357 of the CrPC permits courts to award compensation for any loss or injury caused. We observe one such case in our dataset, where instead of any fine, an amount of Rs. 3 lakhs was directed by the Kerala High Court to be paid as compensation.[152] Notably, the district court in one case and the High Court in 3 cases ordered a combination of fine and compensation - the sum for compensation was ordered to be paid either as a part of the total fine or in addition to the fine.[153] In one case, while the trial court had already directed payment of Rs. 25,000 to the District Legal Service Authority (DLSA)/ court as fine, the district court acknowledged that the family of the victim was yet to be compensated under the Delhi Victim Compensation Scheme even after 2 years, and it sent the order to the DLSA with a request to provide compensation as per the law to the family.[154]

> The shortest sentence for imprisonment was one day, and the longest was 7 years of rigorous imprisonment.

Criminal

Judicial Precedents on Calculating Compensation

Unlike criminal law, there is no prescribed range of compensation that can be awarded in consumer cases. Even though courts and consumer fora have frequently awarded compensation in cases of medical negligence, there exist very few judicial precedents regarding the appropriate method of calculating the quantum of such compensation. Some landmark judgments are mentioned below:

Lata Wadhwa v State of Bihar[155]

The Supreme Court awarded compensation to victims of a factory fire which was caused by the negligence of the employer company and the organisers. Former Chief Justice of India, Justice YV Chandrachud, was requested by the Court to determine the compensation payable. His report advocated the use of the 'multiplier method' to compute compensation by determining the loss of future earnings. This method is best explained in the court's words[156]:

> *Damages are awarded on the basis of financial loss and the financial loss is assessed in the same way, as prospective loss of earnings. The basic figure, instead of being the net earnings, is the net contribution to the support of the defendants, which would have been derived from the future income of the deceased. When the basic figure is fixed, then an estimate has to be made of the probable length of time for which the earnings or contribution would have continued and then a suitable multiple has to be determined (a number of year's purchase), which will reduce the total loss to its present value, taking into account the proved risks of rise or fall in the income.*

In addition to this, the Court laid down factors to calculate pecuniary and non-pecuniary damages:

> Pecuniary damages: "loss of earning or earning capacity, medical, hospital and nursing expenses, the loss of matrimonial prospects"

[142] MANU/AP/0265/2007.
[143] MANU/DE/2615/2014.
[144] MANU/BH/1247/2019.
[145] MANU/DE/3120/2014.
[146] MANU/MH/0759/2019.
[147] MANU/KE/1593/2020.
[148] MANU/TN/3342/2014.
[149] MANU/KE/1593/2020. No reason was provided by the court for the sentencing of the day-long imprisonment. In this case, the failure on part of the accused doctor to detect twin pregnancy on time and the delay in transfusion of blood during delivery caused the death of both the mother and child.
[150] In one case (*Riyazuddin v State, NCT of Delhi* MANU/DE/3120/2014), the trial court had ordered 5 years RI under IPC and 6 years RI under the MTP Act. However, it was not clarified whether the imprisonment terms would run concurrently. For the purposes of our analysis, we have considered them to run concurrently.
[151] *Sanat Kumar v The State of Bihar* Criminal Appeal (SJ) No. 1546 of 2017: MANU/BH/1247/2019; *Riyazuddin v State, NCT of Delhi*, MANU/DE/3120/2014; *Bhupal Malayya Agbattini v State of Maharashtra*, MANU/MH/0759/2019. In these cases, we took the higher term of imprisonment as the effective period of imprisonment for comparison purposes.

[152] *Vasumathy v State of Kerala* Crl. Rev. Pet. No. 696 of 2011: MANU/KE/1593/2020.
[153] For district courts, see *Sunderlal Jain Hospital v State* CA No. 3/17, Court of Additional Sessions Judge-03, North West District, Rohini Courts, Delhi (Out of the fine of Rs 10,00,000 that the hospital had to pay, Rs. 9,00,000 was ordered to be paid to the complainant as compensation). For High Courts, see *Riyazuddin v State NCT of Delhi* MANU/DE/3120/2014 (Out of the fine of Rs 1,05,000, Rs 1,00,000 was ordered to be paid to the complainant as compensation); *Bhupal Malayya Agbattini v State of Maharashtra* MANU/MH/0759/2019 (In addition to a cumulative fine of Rs. 3000, the accused doctor was directed to pay Rs 1,50,000 as compensation to the legal heirs of the deceased victim); *Vasumathy v State of Kerala*, Crl. Rev. Pet. No. 696 of 2011: *Vasumathy v State of Kerala*, Crl. Rev. Pet. No. 696 of 2011: MANU/KE/1593/2020 (only a sum of Rs 3,00,000 was directed to be paid compensation; no fine was ordered).
[154] *Bhagwat Dayal v State* CA No. 109/2017.
[155] *Lata Wadhwa v State of Bihar* MANU/SC/0456/2021.
[156] ibid.

Pecuniary damages: "loss of earning or earning capacity, medical, hospital and nursing expenses, the loss of matrimonial prospects"

Non-pecuniary damages: "loss of expectation of life, loss of amenities or capacity for enjoying life, loss or impairment of physiological functions, impairment or loss of anatomical structures or body tissues, pain and suffering and mental suffering".[157]

National Insurance Company Ltd v Pranay Sethi.[158]
The Supreme Court here affirmed the applicability of the multiplier method for determining compensation. They ruled that the age of the deceased should be the basis for applying a suitable multiplier and that the compensation would be determined after considering the future prospects of the deceased. Though this case relates to the Motor Vehicles Act 1988, this is relevant primarily because the Supreme Court in the following judgment relied on it to determine compensation in a case of death having been caused by medical negligence.

Arum Manglik v Chirayu Health and Medicare Private Ltd[159]
This 2019 judgment is relevant because this is one of the few, if not the only, case of medical negligence where the court has referred to specific precedents - *Lata Wadhwa* and *Pranay Sethi* - for determining compensation. Here, the Supreme Court did not determine the compensation afresh but instead enhanced the compensation previously ordered by the SCDRC.

Arum Manglik is a relatively recent case and its impact on how consumer courts calculate compensation for death by medical negligence is still to be assessed. However, our analysis demonstrates that despite the precedent set by *Lata Wadhwa* and *Pranay Sethi*, courts did not restrict themselves to the multiplier methods in cases of medical negligence. In *Kunal Saha*,[160] an NCDRC order using the multiplier method to calculate the quantum of compensation for loss of dependency was challenged. The Supreme Court was sceptical about adopting a 'straitjacket' multiplier method in medical negligence cases as it might lead to over-compensation. Instead, the court ruled that it is required to determine "just, fair and reasonable compensation on the basis of the income that was being earned by the deceased at the time of her death and other related claims on account of the death of the wife of the claimant".[161]

In another acknowledgement of the limitations of the multiplier method, the Supreme Court, in *Nizam's Institute of Medical Sciences v Prashant S. Dhanaka*,[162] noted that "[T]he kind of damage that the complainant has suffered, the expenditure that he has incurred and is likely to incur in the future and the possibility that his rise in his chosen field would now be restricted, are matters which cannot be taken care of under the multiplier method." In this case, the patient had become a complete paraplegic after surgery was performed. Having held the medical professionals liable for medical negligence, the court ruled that:

> *"Sympathy for the victim does not, and should not, come in the way of making a correct assessment, but if a case is made out, the Court must not be chary of awarding adequate compensation. The "adequate compensation" that we speak of, must to some extent, be a rule of the thumb measure, and as a balance has to be struck, it would be difficult to satisfy all the parties concerned… The support that is needed by a severely handicapped person comes at an enormous price, physical, financial and emotional, not only on the victim but even more so on his family and attendants and the stress saps their energy and destroys their equanimity. We can also visualise the anxiety of the complainant and his parents for the future after the latter, as must all of us, inevitably fade away. We have, therefore, computed the compensation keeping in mind that his brilliant career has been cut short and there is, as of now, no possibility of improvement in his condition, the compensation will ensure a steady and reasonable income to him for a time when he is unable to earn for himself."*

Chandra and Math (2016) note that while calculating compensation in medical negligence cases, courts have taken into account several factors over time, such as loss of income, existing and future medical costs, pain and suffering, litigation expenses, etc.[163] Where the multiplier method is used, they note that the income of the victim is a major factor.[164] This would mean that "compensation that is solely based on the income of the victim would imply that medical negligence causing death or injury to a wealthy individual is worth more than medical negligence that impacts an unemployed individual or homemaker or a child or senior citizen".

How much compensation do consumer forums award?

In consumer law, there is no ceiling limit on the amount of compensation that may be awarded by the consumer commissions across all levels, although of course, fora at different levels have different pecuniary jurisdiction pegged to the value of consideration for goods and services. In our dataset of 360 cases adjudged by consumer fora, we observe that consumer fora award compensation across a wide range. The chart below shows variations in the amount of compensation awarded in different cases across state commissions and the NCDRC. We recognise that these compensation sums are not directly comparable as the cases involve medical negligence which resulted in a range of different harms or injuries. However, we sought to trace the range of sums awarded, the extent to which this varies across district, state and the national commissions, and where possible, to see whether there is any consistency in the range of compensation awarded for cases involving the patient's death across different fora.

> Non-pecuniary damages: "loss of expectation of life, loss of amenities or capacity for enjoying life, loss or impairment of physiological functions, impairment or loss of anatomical structures or body tissues, pain and suffering and mental suffering"

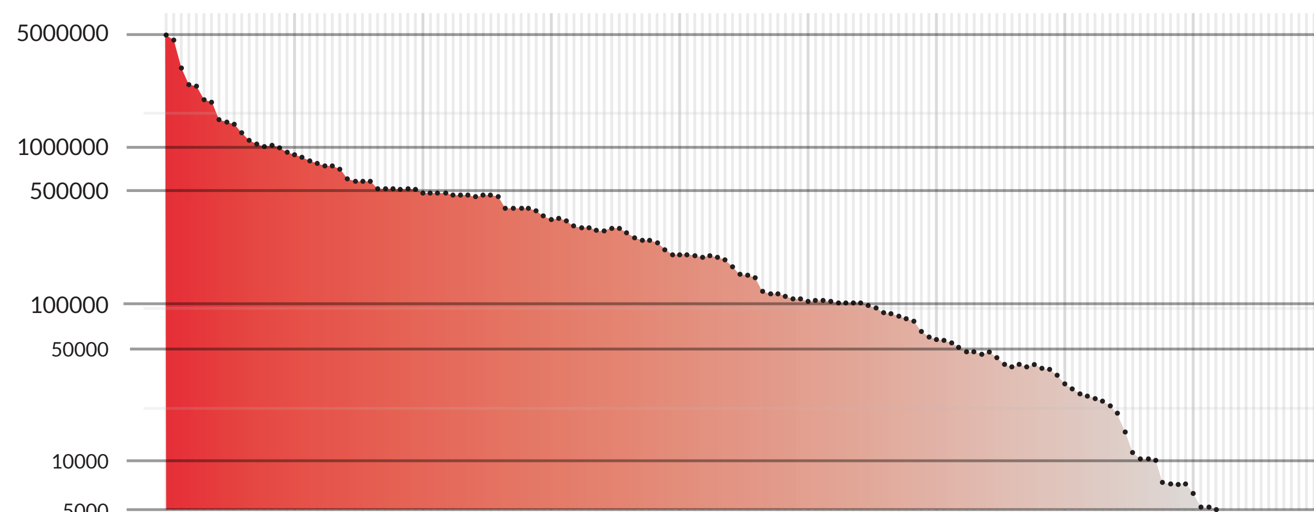
[157] ibid [15].
[158] *National Insurance Company Ltd v Pranay Sethi* MANU/SC/1366/2017.
[159] *Arum Manglik v Chirayu Health and Medicare Private Ltd* MANU/SC/0202/2019.
[160] *Balram Prasad v Kunal Saha* MANU/SC/1098/2013.
[161] ibid [97].
[162] MANU/SC/0803/2009.

[157] Meghana S Chandra and Suresh Bada Math, 'Progress in Medicine: Compensation and medical negligence in India: Does the system need a quick fix or an overhaul?' (2016) 19(1) Annals of Indian Academy of Neurology S21-S27 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5109756/> accessed 14 August 2023. The grounds listed are: loss of income, medical costs till date of judgment, future medical costs, pain and suffering, cost of litigation, inflation and interest, punitive compensation and loss of consortium.
ibid.

Notably, in the majority of cases, the compensation sum awarded lies below Rs. 5,00,000. Across all levels of consumer fora, the largest sum was Rs. 57,74,000,[165] which was awarded by the Tamil Nadu State Commission. In this case, the complainant's son had visited the defendant's hospital for a post-operative checkup but died due to improper administration of anaesthesia and treatment. The compensation was to be paid by the hospital and two doctors jointly and severally. On the other hand, the smallest sum awarded was Rs. 1,687, where the complainant was overcharged while purchasing medicines from the defendant's pharmacy.[166]

If we look at trends across fora, the highest compensation sum awarded by any State Commission is Rs. 57,74,000 as discussed above. The highest sum awarded amongst District Commissions is Rs. 50,00,000, which was against a fertility centre for not testing the egg donor prior to in-vitro fertilisation. As a result, the baby was born with thalassemia. It is interesting to note here that the highest sums awarded by the State and District Commissions respectively are substantially higher than what was awarded by the NCDRC as the highest sum i.e. Rs. 25,00,000. This was awarded for failure on the part of the defendant in maintaining the standard of care while treating a patient admitted for heart surgery. The patient was given an overdose of Heparin and the doctors failed to stop the dosage despite a neurological decline in the patient.[167]
We also looked at the lowest, average and median compensation awarded across different fora, as displayed in table 2.7.

Fig. 2.5 Quantum of compensation awarded by consumer fora



[166] *K Saseendran v Director, Koyili Hospital* CC/131/2011, District Consumer Disputes Redressal Commission, District Consumer Disputes Redressal Commission, Kannur (8 May 2012).
<http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=17%2F550%2FCC%2F131%2F2011&dtofhearing=2012-05-08> accessed 20 August 2023 (Rs 1687 included Rs 187 as the excess amount the complainant was charged, Rs 500 as compensation, and Rs 1000 as litigation expenses).
[167] *Yashumati Devi v Christian Medical College* CC/38/2010, National Consumer Disputes Redressal Commission (11 August 2011)
<http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=0%2F0%2FCC%2F38%2F2010&dtofhearing=2020-08-11> accessed 20 August 2023.

Table 2.7 Statistics related to the quantum of compensation awarded by consumer fora

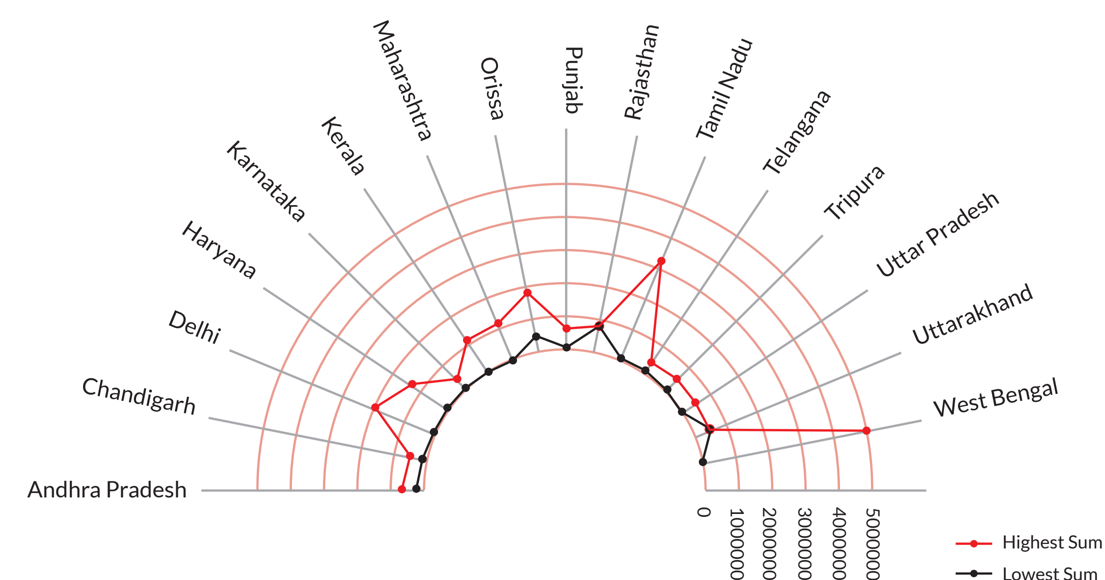
	NCDRC	SCDRC	District Commission
Highest compensation	25,00,000	57,74,000	50,00,000
Lowest compensation	50,000	7,170	1,687
Average compensation	4,57,669.63	7,43,047.97	3,54,056.97

To understand trends with respect to the compensation awarded against the death of the patient due to negligence, we looked at the highest, lowest and average compensation awarded in cases where the patient died.

Table 2.8 Range of compensation awarded by consumer fora for the death of a patient

Highest compensation	57,74,000
Lowest compensation	20,000
Average compensation	7,30,780.27

Fig. 2.6 State-wise comparison of highest and lowest compensation amounts awarded by state and district commissions



In our dataset, we also compare state-wise trends with respect to the highest and the lowest compensation awarded, as shown in the chart below. West Bengal and Tamil Nadu have consistently awarded compensation on the higher end of the scale as compared to other states. Andhra Pradesh, Chandigarh, Karnataka, Telangana, Tripura and Uttar Pradesh have consistently awarded compensations towards the lower end of the spectrum.

How do courts approach and calculate compensation?

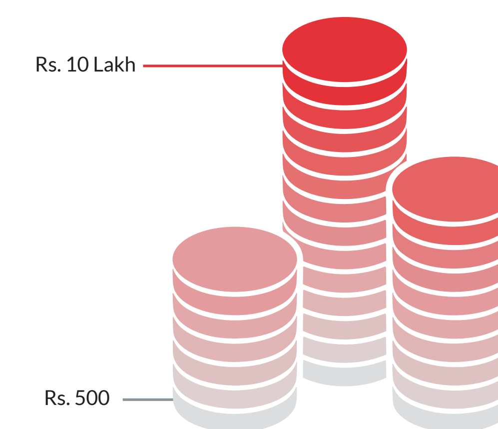
About 62% (i.e. 225) of the 360 cases in our dataset did not involve compensation at all, being cases in which the party accused was not found negligent. We will discuss the remaining 38% (135 cases) i.e. in which compensation was awarded. In this subset, the categories or approaches to compensation ranged between: (a) *lump sum awards under the broad head of compensation*, (b) *reimbursement for medical and other expenses incurred, and* (c) *specific compensation for suffering (physical or mental), mental agony, or harassment.*

Table 2.9 Heads of compensation awarded by consumer fora

Approaches to Compensation	No. of Cases
Single category	
Broad head for compensation for harm / loss	48
Separate head for mental agony / harassment	6
Reimbursement of expenses / costs	5
Multiple categories	
Reimbursement of expenses / costs + Broad head for compensation for harm / loss	44
Reimbursement of expenses / costs + Separate head for mental agony / harassment	12
Reimbursement of expenses / costs + Broad head for compensation for harm / loss + Separate head for mental agony / harassment	11
Broad head for compensation for harm / loss + Separate head for mental agony / harassment	6
Reimbursement of expenses / costs + Separate head for mental agony / harassment + Physical harassment	3
Grand Total	**135**

Out of the 39 cases specifically awarding compensation for suffering, mental agony, or harassment, we noted that all except 3 were cases involving an issue with the course of treatment, diagnosis, or care experienced by the patient, at the hands of a healthcare worker or establishment; the 3 exceptions were cases involving the denial of treatment altogether, a lack of adequate facilities, and overcharging (i.e. charges in excess of those displayed or communicated to the patient at the time of seeking treatment), respectively. 24% (i.e. 33) of the cases where compensation was awarded, were cases in which the patient died. All of these cases involved either broad compensation (26 cases), a separate award for suffering, mental agony, or harassment (9 cases), and included a combination of both; in none of these cases was the award restricted to mere reimbursement for expenses.

Across the dataset, apart from a breakdown of expenses incurred and the corresponding reimbursement calculation, there is generally no express mention of a rationale for awarding a certain sum of compensation. The range of compensation amounts awarded under the head of mental agony and harassment varies greatly as shown in the chart below. The smallest amount awarded was Rs. 500, whereas the largest sum was Rs. 10 lakhs. All of these sums were awarded as part of the total compensation.



The smallest amount awarded was Rs. 500, whereas the largest sum was Rs. 10 lakhs.

[168] *Maya Raghani v The Manager*, Calcutta Heart research Centre Unit of Aloka Medicare (P) Ltd CC/16/296, District Consumer Disputes Redressal Commission, Howrah (5 February 2018) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=4%2F322%2FCC%2F16%2F296&dtofhearing=2018-02-05> accessed 20 August 2023. In this case, the complainant had visited the opposite party diagnosis centre for a test. She paid the specified amount for the test, but the centre alleged that they could only conduct half of the test because the complainant had not come with an empty stomach as was needed for the test. The Commission noted that the complainant was entitled to a refund of the test fees because the centre failed to prove that it had conducted half the test. The Commission specifically noted that since the amount involved is small (Rs 6500), Rs 500 were awarded as compensation for mental harassment and agony as well as litigation costs. See also *P Dati Biddappa v Athreya Hospital* CC/08/88, District Consumer Disputes Redressal Commission, Kodagu (22 October 2008) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=18%2F543%2FCC%2F08%2F88&dtofhearing=2008-10-22> accessed 20 August 2023. In this case, the complainant had undergone delivery at a hospital and was entitled to free care under the Yashaswini Co-operative Farmers Health Scheme. However, the hospital charged the full amount for treatment on the ground that pre-authorisation was necessary to get the benefit. The opposite parties (Health Care Trust and Health Care Scheme) were absent throughout the proceedings.

[169] *Narasingh Paddhi v M/s. Apollo Hospital* CC/25/2004, State Consumer Disputes Redressal Commission, Tamil Nadu (14 June 2018) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=19%2F0%2FCC%2F25%2F2004&dtofhearing=2018-06-14> accessed 20 August 2023. In this case, the complainants' son had died due to improper administration of anaesthesia which caused a fatal cardiac arrest. Rs 10 lakhs was awarded as compensation for "mental agony, hardship and loss of love and affection suffered by the complainants".

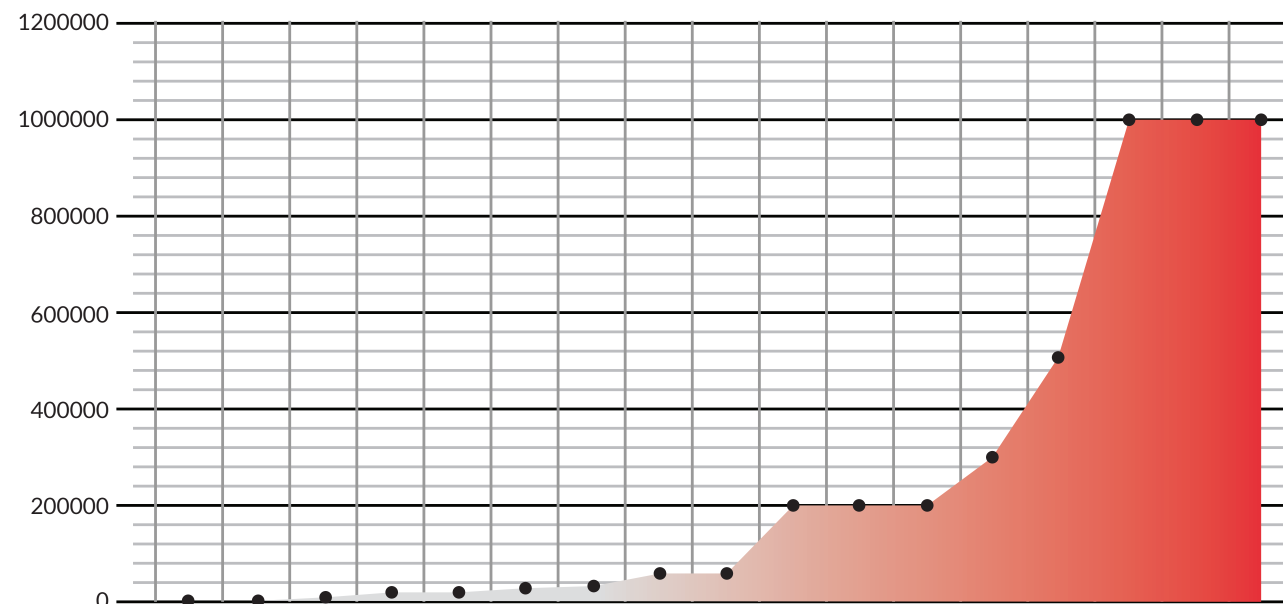


Fig. 2.7 Range of compensation awarded by consumer fora for mental agony

As far as the application of formulae laid down by the Supreme Court is concerned, in our entire dataset, only three cases refer to a precedent or an established rationale for calculation, specifically, the multiplier method (although it was not eventually applied in two of these cases,[170] and was referenced ambiguously in the third[171]). In other cases, the courts either did not specify the reasoning behind their calculations, or only broadly mentioned the factors considered in arriving at a compensation amount, without specifying a particular theory of compensation or established rationale. For instance, in determining an award, the court may take into account the patient's age at the time of death, the extent of the disability caused, the diminution of quality of life of the patient or complainant (as in cases where a complainant lost their mother during the early years of their childhood), or contributory negligence on the part of the patient or complainant.

Apportionment of liability between medical practitioners and healthcare establishments

While the next section exhaustively examines the nature of the litigants and traces within our dataset the proportion of cases filed against both doctors and hospitals, it is appropriate to mention here that when both the doctor and the healthcare establishment are held liable, commissions often omit to mention the apportionment of the compensation amount between them. In our dataset, both the doctor(s) and the healthcare establishment were directed to pay compensation in 54 cases. However, the fora specified the amount to be paid by each respondent to some degree in only 9 cases (16.67%). In all other cases, either there was no mention of any apportionment (15 cases, 27.78%), or the respondents were jointly and/or severally liable to pay compensation (30 cases, 55.56%). Most of the time, the doctor and hospital/medical centre are left to figure out the apportionment between themselves. Within our dataset, there were three cases where the insurance company had to wholly or partly pay the compensation as the healthcare providers were indemnified.[172] In one case, the doctor was insured, and the commission noted that the incident of medical negligence was covered in the insurance policy.[173] Hence, in addition to ordering that the insurance company pay the insured sum of ten lakh rupees to the victim, the commission directed that the doctor personally pay a sum of one lakh rupees as well.

It has been noted by scholars that the individual earning capacity of doctors and their ability to pay compensation is affected by their socioeconomic status, the resources they have in their healthcare establishment, their nature of practice and the experience that they have.[174] They have further argued that in addition to the socioeconomic profile of the litigants, the doctor's capacity to pay compensation as well as their working conditions should also have to be expressly taken into consideration by the court.[175] No consumer commission within our sample took this factor into consideration while determining the quantum of compensation that individual doctors had to pay.

Several scholars have advocated for capping the compensation amount that the court may award in cases of medical negligence.[176] It has been argued that large compensation amounts could trigger an escalation in medical care costs, as the focus of the healthcare professionals moves away from prioritising the care and recovery of patients and shifts more towards protecting themselves from potential malpractice litigation by adding more diagnostic procedures in the fray or by seeking higher insurance cover.[177] At the same time, a cap on compensation may weaken the urgency to improve patient safety, and the limit may not be suitable to certain cases even if the litigated issues are similar to each other.

However, the fora specified the amount to be paid by each respondent to some degree in only 9 cases (16.67%).

[170] *Indrani Chatterjee v Amri Hospitals* CC/383/2013, National Consumer Disputes Redressal Commission (7 July 2011) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=0%2F0%2FCC%2F400%2F2013&dtofhearing=2014-11-07> accessed 20 August 2023; *Yadram v Satish Chaturvedi* RP/4695/2009, National Consumer Disputes Redressal Commission (7 June 2018) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=0%2F0%2FRP%2F4695%2F2009&dtofhearing=2018-06-07> accessed 20 August 2023.

[171] *Sumi Das Indu v Partha Pratim Saha* CC/81/2015, District Consumer Disputes Redressal Commission, West Tripura, Agartala (18 November 2016) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=29%2F273%2FCC%2F81%2F2015&dtofhearing=2016-11-18> accessed 20 August 2023. The doctors were directed to pay Rs 4,00,000 for "cost of treatment, cost of sufferings and litigation cost for their deficiency of service & medical negligence while doing the laparoscopic operation".

[172] *Urmila v Sudhir Verma*, Cygnus JK Hindu Hospital CC/124/2014, District Consumer Disputes Redressal Commission, Sonepat (16 January 2017) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=9%2F81%2F124%2F2014&dtofhearing=2017-01-16> accessed 20 August 2023; *Adari Alies Adar Das v Chief Medical Officer of Health* CC/13/88, Birbhum, District Consumer Disputes Redressal Commission, Birbhum (22 December 2014) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=4%2F314%2FCC%2F13%2F88&dtofhearing=2014-12-22> accessed 20 August 2023; *Doon Valley Hospital v Master Shivabshu* FA/457/2015, National Consumer Disputes Redressal Commission (27 April 2016) <http://cms.nic.in/ncdrcusersWeb/GetJudgment.do?method=GetJudgment&caseidin=0%2F0%2FFA%2F457%2F2015&dtofhearing=2016-04-27> accessed 20 August 2023.

[173] *Urmila* (n 172).

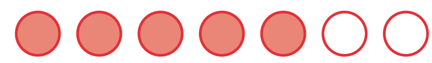
[174] Meghana S Chandra and Suresh B Math, 'Progress in Medicine: Compensation and Medical Negligence in India: Does the System Need a Quick Fix or an Overhaul?' (2016) 19(1) Annals of Indian Academy of Neurology S21-S27 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5109756/> accessed 15 July 2023.

[175] ibid.

[176] ibid.

[177] ibid.

3. A Third Mechanism - Torts



3. A Third Mechanism - Torts

Most of the present-day literature which examines the involvement of the courts in cases of medical negligence is confined to the domain of the above-discussed consumer and criminal laws. We conceptualised this study with a similar presumption. However, during the course of reading the judgments included in our data on medical negligence, we came across 139 judgments delivered by the High Court which operate outside the realm of these two mechanisms. A majority of these cases are appeals arising out of civil suits for damages or writ petitions seeking compensation and are primarily grounded in the law of torts.

This negated our initial presumption that all of the civil claims on medical negligence would be raised only before the consumer fora. We, therefore, decided to include a discussion on these cases in this study not only to track how other civil mechanisms are being used, as we have done for consumer and criminal cases but also to understand what sets these cases apart from the consumer cases. We wanted to understand why these patients approached the civil courts and whether the court was applying the tort law differently from the consumer law.

At the outset, we must sound a caveat that unlike the other two mechanisms examined in this report, we did not seek to systematically collect data on civil suits for damages under tort. Therefore, we do not have data from the district courts on the subject. Instead, our data is only confined to the High Court cases which result from a search of the phrase 'medical negligence' on Manupatra.

We identified 139 cases in our High Court dataset ranging from the years 1980 to 2022.

Fig. 3.1 Geographical distribution of tort cases of medical negligence

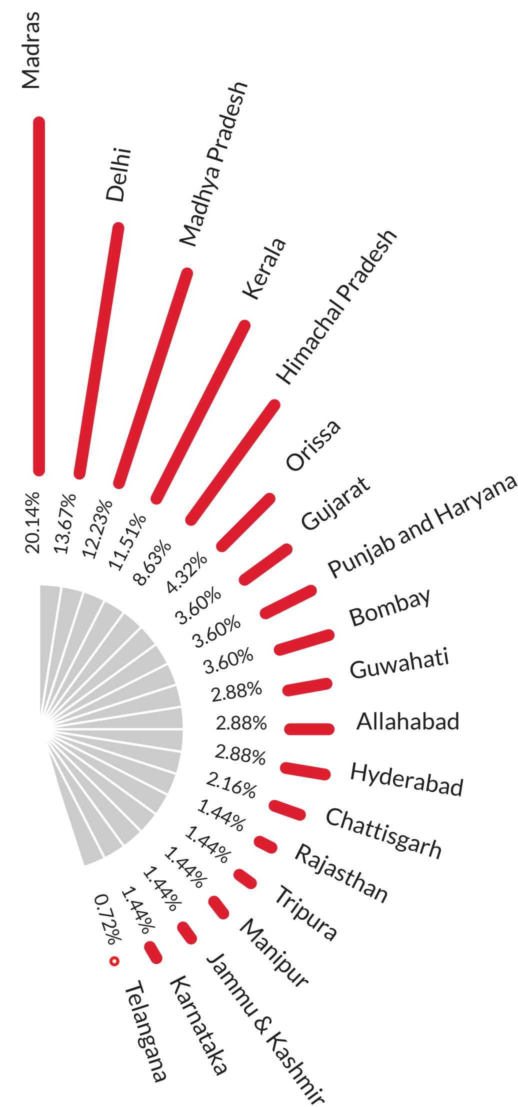
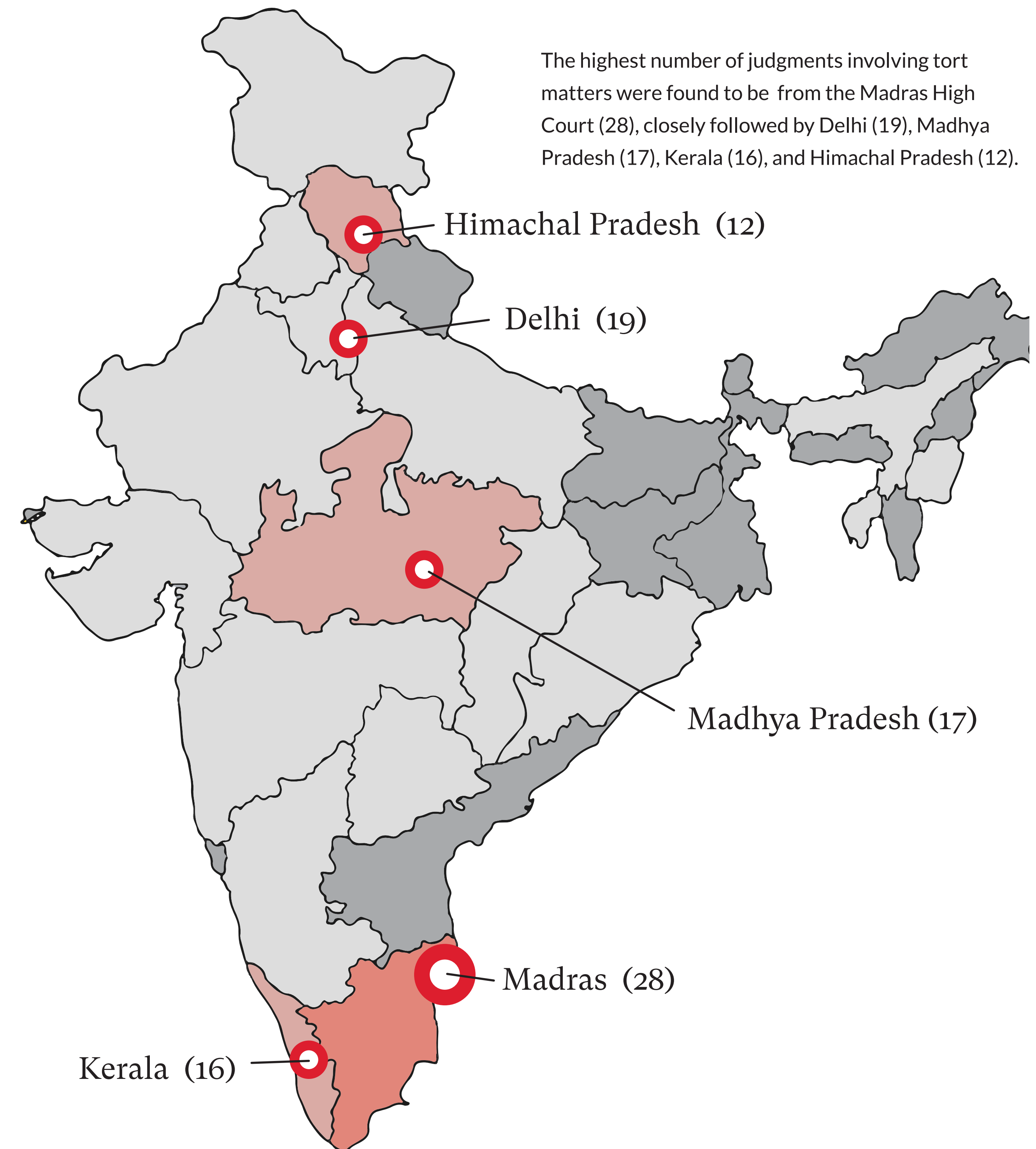


Fig. 3.2 High Courts with the highest number of tort cases of medical negligence



The highest number of judgments involving tort matters were found to be from the Madras High Court (28), closely followed by Delhi (19), Madhya Pradesh (17), Kerala (16), and Himachal Pradesh (12).

Nature of the respondent

Table 3.1 Categories of parties accused of medical negligence in tort cases

Types of Accused Healthcare Provider	Government	Private	Unclear	Both	Grand Total
Both	30	5	5		40
Individual	22	5	5		32
State	20				20
Individual + State	19		1		20
Establishment	13	5	1		19
Individual + Establishment + State	6				6
Establishments + State	1			1	2
Grand Total	**111**	**15**	**12**	**1**	**139**

The vast majority of the cases involved a government healthcare provider (111), whereas only 15 cases involved a private healthcare provider.

In 20 cases, state authorities alone, and not individual medical practitioners, were the respondents, despite the keyword "medical negligence" being present in the case text. In some cases, this was just an omission by the petitioner. For instance, in *Manoj Kumar v State of Himachal Pradesh*, a father sought redress under Article 226 against the state for alleged medical negligence that led to the death of his son in a government hospital.[178] However, neither the attending doctors nor the allegedly negligent Female Health Workers were impleaded as parties. Since the case involved several factual disputes and given that the allegedly negligent healthcare professionals were not parties, the court held that the petitioner had "misconceived his remedies in filing the writ petition" and held that the merit or otherwise of the claim or its proof very much depends upon substantiating seriously disputed factual issues, which must be proved on the basis of oral and documentary evidence. To do so in an Article 226 proceeding with the state being the only opposite party, the court said, would be both impractical and impermissible.

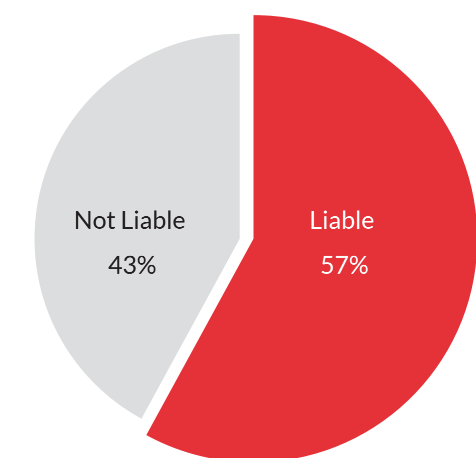
In a number of cases where the defendants were government healthcare providers or state authorities, the issue involved negligence in sterilisation conducted by government doctors as part of government-sponsored camps and family planning operations.[179] At least 35 cases belonged to this category.

[178] *Manoj Kumar v State of Himachal Pradesh* C.W.P. No. 493 of 1992 (Himachal Pradesh HC): MANU/HP/0136/1998.
[179] For example, Lok Nayak Hospital v Prema MANU/DE/2738/2018; Kanagavalli v The Secretary to Government, Department of Health MANU/TN/3749/2009; *Urmila Devi v State of Himachal Pradesh* MANU/HP/0293/2008; State of Gujarat v Bai Sudha MANU/GJ/0916/2002; *The Commissioner, Corporation of Chennai v Kala* MANU/TN/9658/2007.

Outcome

Out of the 139 cases, 110 were decided by the High Courts on merits after appreciating the facts and evidence. Of these in 63 (57%) cases, the healthcare provider was found liable, while in the remaining 47 (43%) cases, they were found not to be liable. This is also the only dataset of cases we examined where such a large percentage of cases ended with a finding of liability.

Fig. 3.3 Outcomes of tort cases on medical negligence



Grounds

Admissibility under writ jurisdiction

One of the issues that often came up before the High Courts was the admissibility of the writ petition under Article 226 seeking compensation on the ground of medical negligence.

In cases where there was a dispute on the facts, the High Court disallowed the writ petition. An example of this is *Rukmani v State of Tamil Nadu*, where the respondents were the state as well as the dean of the government hospital.[180] The petitioner had a sterilisation operation at the hospital, which was unsuccessful. She sought damages for her unwanted pregnancies. The court found that she was entitled to those damages, but that they could not be granted through a writ petition under Article 226 of the Constitution. "In any event," the court held, "the claim for damages could be granted only in appropriate civil proceedings or in a proceedings (sic) before the Consumer Forum."[181] The court justified this on the grounds that there was a specific factual dispute – whether the doctors were negligent – which could be resolved only through a civil trial. Similarly, in *Kshetrimayum Ongbi Bembem Devi v State of Manipur*, the petitioner was the wife of a detainee under the National Security Act who suffered from HIV Infection as well as HCV infection of the liver.[182] The detainee patient had been moved to a hospital from the jail, but it was alleged that proper treatment had not been given. Since there was a dispute as to whether he had been given the correct treatment, i.e. there was a dispute as to facts, the court held that the matter was appropriate for the civil court, and

[180] *Rukmani v State of Tamil Nadu* MANU/TN/0649/2003.
[181] ibid [8.3].
[182] *Kshetrimayum Ongbi Bembem Devi v State of Manipur* MANU/MN/0146/2015.

not for determination in a petition under Article 226. In yet another case,[183] the court cited the decision of the Supreme Court in *Grid Corporation of Orissa Ltd v Sukamani Das (Smt)*[184] noting that where a question of disputed facts arises, the claim for compensation cannot be entertained under the extraordinary constitutional writ jurisdiction. The High Court disallowed the writ petition in a few other cases as well, holding that the petitioner had the option to approach the consumer fora.[185]

However, in a few exceptional cases, the High Court allowed the writ petition based on their peculiar facts. One such example is in the case of *Puli Raju v Government of Andhra Pradesh.*[186] where the petitioner could not approach the consumer fora as the limitation had expired. Allowing the petition, the court observed that from the facts of the case, negligence was clearly established and greater injustice would be caused if the relief is not granted in the exercise of writ jurisdiction and the petitioner is subjected to another remedy.

Burden of proof

Since a significant number of cases at the High Court level (at least 35, as mentioned above) involved alleged negligence by government doctors during the course of sterilisation operations, it is useful to refer to the oft-cited case of *State of Punjab v Shiv Ram*,[187] where the Supreme Court decided a civil appeal in which damages were sought from a government doctor on account of failed sterilisation. In this case, the court held as follows:

> *23. 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.*

In other words, the court held that in order to prove negligence in tort, the *Bolam* test will have to be satisfied. As discussed in the above chapters, the same has also been applied to criminal and consumer cases. Relying on the decision in *Jacob Mathew*, it further held that in criminal prosecutions or claims in tort, the burden always rests with the prosecution or the claimant.

The High Courts refer to the burden of proof explicitly in tort cases, and their operation is particularly evident in cases involving sterilisation. In *State of Tamil Nadu v Amudha*, the court noted that a pregnancy soon after a family planning operation demonstrably shifted the burden of proof onto the healthcare provider.[188] The state was now required to provide alternative explanations and show a lack of negligence; since they did not, they were held liable. But the way in which the burden shifts is sometimes inexact, and depends on the specific facts. For example, in *Asha Devi Gupta v Union of India*, the plaintiff got pregnant despite her husband having had a sterilisation operation.[189] The High Court said that the principle of *res ipsa loquitur* could not be applied merely because the plaintiff had become pregnant, and that the essential element of negligence could not be inferred merely from the pregnancy. The court noted that facts other than negligence, including a failure by the patient to take advised precautions, could have led to the failure of the vasectomy. Squarely placing the burden of demonstrating that he had taken these precautions on the patient, the court said "it was for Rajaram (the husband) to state in detail not only the advise (sic) given but also to state that he duly observed each and every precaution advised by the Doctor." In this case, such a statement had only been given by his wife, and the court dismissed her appeal. The courts also sometimes infer causation where ready alternative explanations do not exist; the burden of proof acts as a mechanism to force the state to provide these explanations. In *Parveen Begum v State of Himachal Pradesh*, the petitioner's eight-month-old daughter was vaccinated against DPT, leading to the paralysis of her left leg. Among other points, the petitioner argued that since the petitioner's daughter was asymptomatic, and was paralysed after the injection, the principle of *res ipsa loquitur* applied. The burden of proof was thereby shifted, and the court granted lump-sum compensation.[190]

In one revision petition from a civil case, *Parbati Das v State of Tripura*, the plaintiff below sought a referral to a particular medical department for expert opinion on the case. However, the district judge ruled that providing evidence of negligence was the plaintiff's responsibility. In their arguments in the revision petition before the High Court, the plaintiff-petitioner argued that "no medical expert will turn up because all are professional colleagues" of the defendant doctors. The High Court upheld the trial judge's decision, stating that this suspicion was unfounded, and that professionals have a legal duty to discharge to the public.[191]

[183] *Kamalini Biswal v State of Orissa* MANU/OR/0178/2001.
[184] *Grid Corporation of Orissa Ltd v Sukamani Das (Smt.)* MANU/SC/0572/1999 .
[185] *Naval Singh Jatav v State of Madhya Pradesh* MANU/MP/0617/2020.
[186] *Puli Raju v Government of Andhra Pradesh* MANU/TL/0025/2019.
[187] *State of Punjab v Shiv Ram* MANU/SC/0513/2005.
[188] *State of Tamil Nadu v Amudha* MANU/TN/8274/2019.

[190] *Parveen Begum v State of Himachal Pradesh* CWP No. 1316 of 1993 (Himachal Pradesh High Court): MANU/HP/0111/1995.
[191] *Parbati Das v State of Tripura* MANU/TR/0071/2018.

Remedies awarded

In most cases, the remedy sought from the courts were damages and compensation. We recorded this amount of compensation awarded in each judgment where liability was found. This calculation does not include interest calculations or compensation awards where the exact figure was not specified.

Fig. 3.4 Quantum of compensation awarded in tort cases on medical negligence

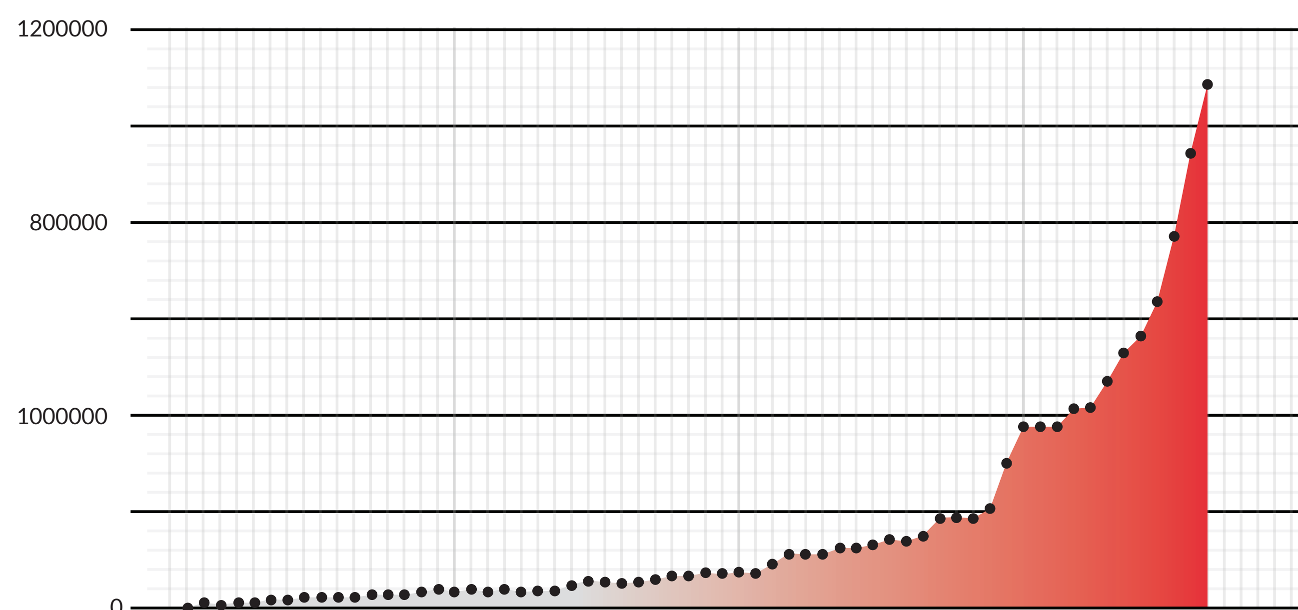


Table 3.2 Statistics related to quantum of compensation awarded in tort cases of medical negligence	
Distribution	**Amount in Rupees**
Lowest Compensation Awarded	4,000
Highest Compensation Awarded	28,70,000
Average	4,64,567
Median	2,00,000
Standard Deviation	6,17,200

The lowest compensation of Rs. 4,000 was awarded by the Madhya Pradesh High Court in 1984.[192] The issue pertained to a negligently conducted surgery in the year 1968, because of which the wife of the appellant had died. In this case, the appellant claimed only symbolic damages, and the court awarded him Rs. 3,000 for loss of service and Rs. 1,000 for mental agony and physical suffering. The court itself while giving the award noted that the amount claimed was too low. In comparison, the highest compensation was awarded by the Madurai bench of the Madras High Court in 2016 in a writ petition.[193] In this case, the government establishment negligently administered Nitrous Oxide to the patient instead of oxygen causing her death. In addition, the court found the state to be vicariously liable to pay damages. Applying the multiplier method, the court awarded a total sum of Rs. 28,37,000 under the heads of (A) loss of income of the deceased, (B) medical expenses, (C) non-pecuniary damages, (D) loss of personal income. An additional Rs. 33,000 were given towards costs.

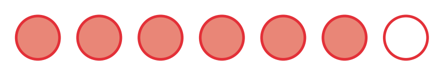
Clearly, the range of compensation is wide, with a standard deviation of Rs. 6,17,200. The figures are often influenced by individual, large judgments, as opposed to following a consistent pattern in how or why the courts award compensation. For example, while the median compensation awarded across all cases was Rs. 2,00,000, one case involving negligence by both hospital authorities and the police led to the Madras High Court awarding Rs.15,00,000 in compensation.[194]

The average compensation when the defendant was an individual doctor was Rs. 3,59,111. In a plurality of cases, where both the doctor and the establishment were defendants, the average compensation was Rs. 3,54,736. Once again, we emphasise that these figures are not to be relied upon as representative of the award of damages across the civil courts, but only represent a subset of cases that come up for appeal. These figures also include compensation awards in writ petitions, which are far more discretionary, and may not follow a fixed pattern.

However, in a few cases, the High Courts directed ex-gratia payment even though no case for awarding damages could be made out. In one case the Madras High Court took cognizance of the fact that even though no medical negligence may have been established against the government establishment or doctor, unanticipated injury may be caused to the patient or their family. The High Court thus directed the state to disburse ex-gratia payment to the patient.[195] Similarly, in a few cases, the High Courts have also directed the State and Central Government to make ex-gratia payments to the patients treated at government hospitals or their legal heirs in accordance with existing government schemes.[196] Quite interestingly, we came across one outlier case, where a government doctor had approached the High Court against the decision of the disciplinary authority where the doctor had been ordered to take compulsory retirement on being found liable for medical negligence.[197]

[192] *Ram Bihari Lal v JN Shrivastava* MANU/MP/0030/1985.
[193] *S Ganesan v The Secretary to Government, Health Department, Government of Tamil Nadu* MANU/TN/2450/2016.
[194] *Muthulakshmi v The Secretary to the Government of Tamil Nadu* MANU/TN/5479/2022.
[195] *N Fauzia v S Balasubramanian*, S.A. (MD) No. 72 of 2014: MANU/TN/9906/2021.
[196] See for instance, *The Collector of North Arcot v K Mani*MANU/TN/3846/2010; *Gyanadutta Chouhan v The Additional Chief Secretary to Government, Health and Family Welfare Department, Government of Odisha*, MANU/OR/0083/2022.
[197] *TC Barjatia v State of Rajasthan*, S.B. Civil Writ Petition No. 5038 of 2007: MANU/RH/0955/2013.

Conclusion



Conclusion

Patients and their families undergo significant trauma in addition to financial burden when the faith they reposed in their doctor is misplaced and they become victims of medical malpractice. On their part, the deviance of some doctors subjects the entire profession to a bad reputation and fear, giving rise to defensive medicine. The objective of this study was to understand the broad trends behind the litigation by aggrieved patients against healthcare providers. For this, we created a large dataset of consumer and criminal cases from online sources.

We observed that a large number of criminal complaints against healthcare providers are dismissed before the trial even commences, primarily on the ground of the prosecution either not obtaining expert medical opinion in consonance with *Jacob Mathew* and *Martin D'Souza* or failing to establish a prima facie case against the healthcare provider. While medical negligence cases under Section 304A of IPC cannot be adjudicated on the basis of *res ipsa loquitur* and must be determined as per medical evidence and expert findings, consumer law has no such limitation on the application of *res ipsa loquitur*.

In both consumer cases as well as Section 304A at the district court level, we observed that a large number of cases were in favour of the healthcare providers. However, the proportion between those held liable is more balanced in consumer cases as compared to criminal cases: in consumer commissions, the healthcare providers were held liable in 43% of the cases, whereas in Section 304A district cases, the conviction rate was only 6%. Notably, while in criminal complaints the accused was often an individual medical practitioner, consumer complaints were frequently filed against both the medical practitioner and the healthcare establishment they practised in.

In criminal cases of medical negligence where the healthcare provider was convicted, a fine and/or compensation was imposed on them in addition to imprisonment as per the prescribed term. These fines/compensation were observed to be within a fairly large range. Consumer commissions awarded an even larger range of sums as compensation under various heads, such as mental agony, litigation expenses, loss of love and affection, etc. Worryingly, most of these cases did not include any express rationale for the compensation awarded, thereby underscoring the necessity of ensuring consistency in the application of principles for calculating compensation.

An interesting observation was that several cases before the High Courts were filed under tort law. While our data collection for such cases was confined to High Court cases involving medical negligence only, we observed that an overwhelming proportion of cases were filed against government healthcare providers, and unlike criminal and consumer cases, the healthcare provider was held liable in more than half of these cases.

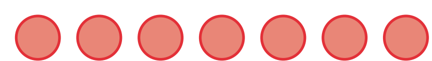
In sum, the courts have attempted to do justice to both the healthcare providers and the patients. However, as judicial bodies, they do not have the expertise to decide complex matters of medical negligence and are constrained to rely on expert assistance. This is not a reliable and foolproof mechanism. Instead of requiring expert medical opinion as a knee-jerk response to every medical negligence case, more careful considerations and analyses are needed to determine which situations require expert medical opinion and where other evidence is conclusive to determine medical negligence. In cases where expert opinions are sought, it is important to explore ways to reduce any potential bias. Having permanent medical boards at the district level for this purpose can prove to be an effective, unbiased and time-sensitive mechanism to seek medical opinion. This will ensure the timely delivery of justice for victims while preventing healthcare providers from being subject to unjustified harassment.

Further, approaching the courts for relief needs to be an exceptional remedy of the last resort. Instead, emphasis needs to be on reforming the healthcare system in the country by executive action. The government needs to take concrete steps to mitigate instances of medical negligence by improving the regulatory framework. Healthcare establishments need to be incentivised to develop internal grievance redressal mechanisms so that the woes of the patients can be resolved at the initial stages itself rather than both parties engaging in long-drawn and expensive legal proceedings. To this end, the table below sets out some key recommendations for strengthening grievance redressal mechanisms at healthcare establishments, and reforming the criminal and consumer adjudicatory process for medical negligence cases.

Key recommendations

For the Central Government		For the State Governments		
Issue guidelines to educate consumer fora, district courts, healthcare providers and establishments about the developments concerning the *Bolam* test and the appropriate standard for medical negligence.	Frame rules under the Consumer Protection Act to guide the use of expert opinion and the calculation of compensation in cases involving medical negligence.	Draft rules to replace the Supreme Court's guidelines in *Jacob Mathew*, taking into account the experience with implementing these guidelines over the last 18 years.	Set up permanent district medical boards to provide expert opinion in medical negligence cases on the lines of Supreme Court's order in *Jacob Mathew*.	Frame rules under the Clinical Establishments (Registration and Regulation) Act, 2010 and analogous legislations mandating internal grievance redressal systems at all healthcare establishments.

Annexure - Detailed Methodology



Annexure - Detailed Methodology

Consumer Courts

Sourcing

The data was scraped from Computerization and Computer Networking of Consumer Forums in Country (CONFONET). This is an online portal for filing and tracking cases under the Consumer Protection Acts. We searched for judgments of disposed cases using Free Text Search for the following keywords:

- Medical Negligence
- Clinic
- Doctor
- Hospital
- Medicine
- Nursing
- Patient
- Surger

This search was run for all years across all District, States and the National Consumer Disputes Redressal Commissions. This yielded 28,629 results including cases from the NCDRC, 36 SCDRCs and 272 District CDRCs. The data ranged from the years 1992 to 2022. However, over 90% of the data is from 2011 onwards

Filtering

To narrow down the number of cases, the following steps were undertaken:

1. Cases where the text was not available on account of the "order was not uploaded" error were eliminated
2. Cases where either of the party names included the following words were extracted for the purpose of the study:

   Dr\.|hospital|patholo|medical|centre|center|diagnos|nursing|orthoped|dental|eye|special|medanta|heart|clinic|ultrasound|scan|vascular|institute|urological|research|sight|veternity|style|mgs|union of india|leproscopy|urelogy

   These words were identified by looking at the party names of about a 100 relevant cases for the study. This yielded about 7005 cases.
3. These were further filtered down by removing the words insurance/ assurance/ LIC from the party names as these cases generally pertained to private litigation regarding insurance claims between individuals who had "Dr" in their names and their insurance agencies.
4. About 74 orders on interlocutory applications were removed as these applications generally concern procedural issues and these orders do not finally dispose of the matter. We noticed that all these 74 orders were issued by the State Commission of West Bengal.
5. From these, we further removed cases which included the following words, after a preliminary review of the judgment to verify that the case in question did not primarily involve healthcare disputes.

   bank, icici, 'technolog', hospitality, courier, builder, holiday, TPA, railway, telecom, engine, airline, realty, mototr, airways, 'electric', infrastructure, 'develop'
6. Around 130 orders that were in Hindi or Marathi were removed. This included 73 cases from Maharashtra, 2 from Rajasthan and 46 from Uttar Pradesh (including 39 from Uttar Pradesh State Commission)

Finally, this helped us narrow down the dataset to 5996 judgments. This included judgments from the NCDRC, 27 state fora, and 191 district fora.

Sampling

Since it was not possible to manually read such a large number of cases, we created a smaller sample of cases to include in our analysis. By taking a confidence level of 95% and a margin of error of 5%, we arrived at a sample size of 360 cases. We decided to draw this sample randomly and proportionately from all states and the NCDRC. The parameters of the sample are described below:

- Proportionate stratification across states: Our sample has proportionate representation from each state in the population. Example: our population of 5996 cases consists of 19% judgments from Kerala. Therefore, 19% of the judgments in our sample are also from Kerala.
- Overall stratification across the three tiers of consumer fora: Overall, our sample has been drawn proportionately across the three tiers from the population of cases. Example: about 20% of the population comprises NCDRC cases, 31% comprises State Commission decisions and the remaining 49% comprises decisions given by the District Fora. This is reflected in our sample in the same proportions.

  However, the sample has not been drawn proportionately from the two tiers of consumer fora within each state. This is because, at the outset of the study, we presumed that there should be no fundamental difference in the way the State Commissions or the District Fora decide these cases and thus stratification at this level was not considered significant for the purposes of the study. Example: if 28% of all the cases from Kerala were decided by the State Commission, our sample from Kerala may not necessarily have exactly 28% representation of State Commission decisions.
- No stratification across districts: Our sample is not representative of the number of decisions delivered by each district forum. This is because most districts include very few cases and to have 1 whole case represented in the sample of 360 cases, a district would need to have at least 17 cases. Otherwise, drawing a representative proportion would yield illogical results. Example: about 69% of the districts in our population had less than 17 cases. New Delhi district had 6 cases (0.1% of the total cases). To represent New Delhi proportionately in the sample of 360 cases would imply including 36% of a single case which is an illogical number.

Analysis

These 360 cases were read manually by a team of 8 persons to capture additional qualitative data points. This included manually recording the answers to the following questions:

- Is the accused an individual or establishment? (Individual/ Establishment/ Both)
- Is the healthcare provider a private or a government entity? (Private / Government)
- Main issue decided by the court (Open-ended)

- Keywords of issues (Medical negligence, overcharging, etc)
- Was the case decided on merits? - Eg: a case decided on limitation or jurisdiction issues will be 'no'. A case decided on whether the patient was a consumer or if there was negligence would be 'yes')
- Outcome (Not liable/liable)
- Who was held liable? (eg: Hospital/Doctor/Both/NA)
- What was the evidence relied on? (Eg. res ipsa loquitur, reference to medical literature, expert opinion adduced by parties, independent board of medical experts)
- Reason for holding liable (open-ended)
- Nature of penalty (imprisonment/fine/reimbursement/compensation/etc)
- Total quantum of the compensation? (open-ended)
- Quantum for Mental Agony
- How was this quantum calculated? (open-ended)
- Any other direction (open-ended)
- Name of legal test applied (if applicable)
- Was a landmark decision relied upon (Jacob Mathew/ VP Shantha/ Martin D'Souza / Nikhil Super Speciality/ Kunal Saha/ Spring Meadows/ Samira Kohli/Kusum Sharma)
- If yes, in what context? (open-ended)
- Additional comments/ notes
- Did the patient die? (No/Before Complaint/After Complaint)

The data entered in this way was reviewed by one of the authors to check for inconsistencies and correctness.

After the conclusion of this analysis and external peer-review, we realised the need to revisit the database and analyse trends in the kinds of matters litigated, the judicial decision-making process, and how compensation is conceptualised in these cases. The objective was to understand the consistency or variance in how these matters were approached and decided. We hope that this also helps devise recommendations or guidelines pertaining to legislative and judicial approaches towards medical negligence under consumer law, if deemed necessary.

Therefore, for a second round of analysis, a team of 2 researchers worked on a fresh set of questions with reworked options, and used Google Forms to input information about the same database of 360 cases over a period of about two weeks. An initial sample of 30 cases was studied to understand the kinds of data that can and should be recorded, and the options/ categories that would optimally capture such data. The questionnaire went through a few iterations over the course of the analysis, and attempts were made to minimise human error through regular discussion and review.

All questions were compulsory in the form, with an option to mark 'none' or 'not applicable' where necessary. An option for 'other' was provided in case the need for a separate category was felt by the researchers and added after mutual discussion. While the options were kept fairly uniform for ease of analysis, the 'comments' recorded more subjective observations or notes made by the researchers. The final iteration of the questionnaire is reproduced below (the options/ categories are explained in relevant sections throughout the body of the report):

1. ***Alleged violation or deficiency of service***
- Issue with diagnosis
- Issue with care or course of treatment
- Lack of competence of treating physician / HCW
- Inadequate facilities
- Denial of service (treatment)
- Delay in treatment/ testing/ report delivery
- Failure to obtain informed consent
- Overcharging
- Unnecessary testing
- Refusal to provide patient records
- Failure to disclose information regarding patient's condition, available facilities, or other pertinent information
- None
- Not applicable
- Other:

2. ***Kinds of harm alleged***
- Death
- Temporary disablement
- Permanent disablement
- Temporary inability to work / study
- Financial loss
- Suffering (physical / emotional) / mental agony / harassment
- Unfavourable outcome / issue not resolved
- Not applicable
- Other:

3. ***Medico-legal evidence considered (as mentioned) by court***
- Expert opinion
- Opinion of existing medical board
- Opinion of specially constituted medical board
- Medical literature
- None
- Not applicable
- Other:

4. ***Legal principle considered (as mentioned) by court***
- Established legal doctrine / principle (this includes principles laid down in landmark cases, and referenced in the present judgment without explicit reference to the landmark case in question)
- Case law
- None
- Not applicable
- Other:

5. ***Basis of decision***
- Decision on merits
- Decided on legal principles (not specific to medical facts in issue)
- Decided on technical grounds like limitation, jurisdiction, etc.
- Not applicable
- Other:

6. ***Heads of compensation awarded***
- Reimbursement of expenses / costs
- Broad head for compensation for harm / loss
- Separate head for mental agony / harassment
- Physical harassment
- Not applicable

7. ***Comments***

Limitations:

1. In a best-practices document on the CONFONET website, the National Informatics Centre notes that "many consumer forums including state commission are not doing correct data entry" and that "they are not updating/entering the daily orders regularly."[198] The reliability of our data is subject to the possible inaccuracies, delays, or omissions by the concerned authorities in uploading orders or metadata on CONFONET.

[198] National Informatics Centre, 'DATA QUALITY OF CASES ENTERED THROUGH CONFONET APPLICATION (CMS)' <https://confonet.nic.in/manuals/CMSQuality.pdf> accessed 26 May 2023.

2. The CONFONET dataset was obtained through web scraping, which relies on automated methods to extract data from websites. Automated web scraping is vulnerable to issues that can affect accuracy and reliability, including errors in the design and implementation of the web scraping program.
3. Most of our data includes judgments delivered from 2010. This is because the CONFONET Scheme was launched in 2005 under the 10th Five Year Plan and expanded only under the 12th Five Year Plan, post which digitisation of these orders became prominent.[199]
4. Judgments delivered in languages besides English have not been included in our data. Therefore, the data is not representative of consumer litigation across the country. For example, there are no cases from Chhattisgarh or Gujarat in our data.
5. The data from Maharashtra, Rajasthan and Uttar Pradesh is skewed by the fact that some of the fora in these states delivered judgments in regional languages while others delivered the judgments in English.
6. We drew our sample proportionately from a population of 5996 cases. However, since we could not manually review each of these cases, we cannot be certain that all of these were relevant. Therefore, the actual proportion of consumer cases in each state might be different from what we have recorded in this study.
7. The sample is not proportionally representative of the decisions given by each tier of the consumer fora within a particular state. It is also not proportionately representative of the decisions given by each district in the country.
8. Our data has been created using specific search words. While we have tried to be exhaustive, it is possible that we have inadvertently excluded other relevant cases which did not contain any of our search words.
9. Our analysis involved reading each of the judgments in our dataset manually, both for filtering the relevant cases and for extracting relevant information. It is therefore possible that there may be few inaccuracies or human errors in collecting and analysing the data despite our best efforts to mitigate these.

[199] Ministry Of Consumer Affairs, Food And Public Distribution, *Standing Committee On Food, Consumer Affairs And Public Distribution* (Demands For Grants 2013-14), laid in Rajya Sabha on 30.04.2013, 117 <https://eparlib.nic.in/bitstream/123456789/64224/1/15_Food_Consumer_Affairs_And_Public_Distribution_29.pdf> accessed 6 May 2023.

Criminal Law

Sourcing

We scraped the district ecourts website[200] for the final orders or judgments of all cases that had been disposed of under Section 304A of the IPC, that is, where the death of the victim was caused by the alleged negligence of the healthcare provider. We obtained 60,934 results from this search.

Filtering

Not all of these search results were relevant to the study. To narrow down the search results the following steps were taken:

- Cases where the copy of the judgment/order was not uploaded or the link to the copy was broken were removed
- Bail matters were excluded as these do not finally decide the merits of the cases
- Cases where legislation which are irrelevant to the study were mentioned, such as, the Motor Vehicles Act, 1988, the Electricity Act, 2003, and the Explosives Act, 1884 were removed.
- From under the column labelled 'section' (i.e., the provision of law under which the case has been filed), cases falling under section 279 (rash driving) and 288 (repairing buildings) were removed as these are associated with offences committed under the Motor Vehicles Act, 1988. Similarly cases involving 'dowry death' were filtered as these are generally concurrently filed under sections 304B and 406 of the IPC.
- Only orders which were filed under 'Copy of Judgment', 'Decree or Copy of Final Order' etc were extracted. Orders filed under 'Copy of Order' or 'Copy of Judicial Proceedings' were excluded as these do not finally dispose of the case.
- Cases which were disposed of by virtue of being settled out of court or the withdrawal of the complaint were also removed.
- This left us with about 9274 cases. All of these were read manually by a team of 6 persons to identify relevant cases.

After cleaning up the data in this way, only 80 judgments were found to be relevant for the study. It must be noted that several district courts in Chhattisgarh, Gujarat, Maharashtra, Odisha, Rajasthan, Tamil Nadu, Uttar Pradesh and Andhra Pradesh publish judgments in local languages, including Hindi, only. These have not been included in the study because of limitations in expertise in reading and analysing judgments in these languages.

Analysis

These 80 cases were re-read manually by the authors to capture additional qualitative data points. This included manually recording the answers to the following questions:

- Is the accused an individual or establishment? (Individual/ Establishment/ Both)
- Is the healthcare provider a private or a government entity? (Private / Government)
- Was the case decided on merits? - Eg: a case decided on limitation or jurisdiction issues will be 'no'. A case decided on whether the death was caused by medical negligence would be 'yes')
- Outcome (acquittal/conviction)
- Who was held guilty? (eg: Hospital/Doctor/Both/NA)
- Reason for conviction or evidence relied upon (open-ended)

[200] Official Website of District Court <https://districts.ecourts.gov.in/>

- Nature of penalty (imprisonment/fine/ reimbursement/compensation/etc)
- Total quantum of the penalty? (open-ended)
- How was this quantum calculated? (open-ended)
- Any other direction (open-ended)
- Name of legal test applied (if applicable)
- Was a landmark decision relied upon (*Jacob Mathew/ VP Shantha/ Martin D'Souza / Nikhil Super Speciality/ Kunal Saha/ Spring Meadows/ Samira Kohli/Kusum Sharma*)
- If yes, in what context? (open-ended)
- Additional comments/ notes

Since all of these cases pertained to death caused by alleged medical negligence, additional information about the main issue involved in the case was not recorded.

Limitations

1. This dataset is sourced from the e-Courts project, which carries a disclaimer stating that "[n]either the Courts concerned nor the National Informatics Centre (NIC) nor the e-Committee is responsible for any data inaccuracy or delay in the updation of the data on this website."[201] Further, visitors are "requested to cross check the correctness of the information on this site with the authorities concerned or consult the relevant record."[202] The reliability of our data is subject to possible inaccuracies, delays, or omissions by the concerned authorities in uploading orders or metadata.[203]
2. The e-Courts dataset was obtained through web scraping, which relies on automated methods to extract data from websites. While some issues are mitigated by the general standardisation and static nature of the e-Courts websites, automated web scraping is still vulnerable to issues that can affect accuracy and reliability, including errors in the design and implementation of the web scraping program.
3. Most of our data on district courts includes judgments and orders delivered after 2013. This is because the digitisation of court decisions began with the launch of the e-Courts portal in 2013 and judgments delivered prior to this date have not been uploaded online by most district courts and High Courts.[204]
4. Judgments delivered in languages besides English have not been included in our data. Therefore, the data is not representative of consumer litigation across the country. For example, there are no cases from Chhattisgarh, Gujarat, Madhya Pradesh, Rajasthan or Uttar Pradesh in our data.
5. The data from Maharashtra is skewed by the fact that some of the district courts in the state delivered judgments in Marathi while others delivered the judgments in English. Therefore, the data is not representative of the litigation in the entire state.
6. Our search is confined to only death by medical negligence cases, as filed under section 304A. This is not reflective of the entire criminal litigation in the cases of medical negligence. We decided to keep this search narrow due to the financial and capacity complaints of doing a wider search through web scraping.
7. It must be noted that these numbers are based on the final judgment of the district courts and not the actual number of criminal cases filed under section 304A. Therefore, higher decisions from the courts of a particular state may not be reflective of a higher number of medical negligence cases in the state.
8. Our analysis involved reading each of the judgments in our dataset manually, both for filtering the relevant cases and for extracting relevant information. It is therefore possible that there may be few inaccuracies or human errors in collecting and analysing the data despite our best efforts to mitigate these.

[201] 'Disclaimer' <https://districts.ecourts.gov.in/disclaimers> accessed 30 October 2023.
[202] ibid.
[203] For a more detailed discussion on issues with e-Courts data, see Devendra Damle and Tushar Anand, 'Problems with e-Courts data' (2020) National Institute of Public Finance and Policy Working Paper No. 314 <https://www.nipfp.org.in/media/medialibrary/2020/07/WP_314__2020.pdf> accessed 26 May 2023.
[204] 'E-Courts Mission Mode Project | Official Website of e-Committee, Supreme Court of India | India' <https://ecommitteesci.gov.in/project/brief-overview-of-e-courts-project/> accessed 5 May 2023.

Constitutional Courts

Sourcing

While we had scraped the data for district courts and the consumer fora from the official websites, we decided to not do the same for the High Court and the Supreme Court cases. This is because web scraping requires external assistance and is thus time consuming and expensive. However, there is no alternative source of gathering data on decisions given by district courts and district consumer fora. In the case of High Courts and the Supreme Court, there are independent private aggregators who have this data readily and freely accessible.

We thus entered into a partnership with Manupatra, a private online aggregator of legal information including court orders, under which they shared details of all judgments delivered by the High Courts and the Supreme Court wherein the phrase 'medical negligence' was mentioned.

They shared with us a CSV file containing the details of 1301 judgments from across High Courts and 107 cases from the Supreme Court. Since this was a broad search term, not all of the cases we received were relevant, that is, not all the cases arose out of allegations of medical negligence against a healthcare provider.

Filtering:

- Cases where legislation which are irrelevant to the study were mentioned, such as, the Motor Vehicles Act, 1988, the Electricity Act, 2003, and the Explosives Act, 1884 were removed.
- In the headnotes of the cases, we applied a filter for words such as 'electricity', 'dowry', 'motor vehicle' etc which were likely to be indicative of an irrelevant case. We reviewed the headnotes of these cases and eliminated the cases which appeared irrelevant after this preliminary review.
- The remaining 996 High Court cases were read manually to identify relevant cases. This gave us a dataset of 416 cases which were re-read in detail to capture additional data points. The remaining 89 Supreme Court cases were also similarly read to identify relevant cases. Finally, our dataset comprised 62 Supreme Court decisions.

Categorising:

High Courts - The issues litigated before the High Court under the broad term 'medical negligence' were varied. They originated out of different legislation and attracted different remedies. We therefore categorised the dataset into four broad groups:

1. Consumer Cases (13 cases) - These were cases which originated out of complaints filed under the Consumer Protection Acts of 1986 and 2019.
2. Criminal Cases (226 cases) - These pertained to offences under the Indian Penal Code (such as sections 337, 338, 420 and 304A) as well as other legislations like Medical Terminal of Pregnancy Act, 1971 and Prevention of Corruption Act of 1988. As opposed to the district courts where we had confined our search to only cases filed under section 304A, we decided to keep the dataset at the High Court level wide to get a wider understanding of the criminal litigation landscape in the cases of medical negligence.
3. Suits for damages/ Tortious Cases (139 cases) - The High Court cases included claims arising out of civil suits for damages as well as writ petitions seeking compensation against the alleged medical malpractice. Since these cases lay outside the purview of both consumer and criminal law, we decided to study them separately. Despite the fact that a study of tortious liability had not been accounted for in the initial scope of our research, we decided to retain these cases as we were interested in understanding any litigation by which the patients and their families were holding healthcare providers accountable for medical malpractice.
4. Cases arising out of Medical Council Acts and Clinical Establishments Acts (38 cases) - These cases arose out of pleas against regulatory and disciplinary decisions given by the national or state medical councils (such as suspension of registration, or procedure followed while investigating a complaint of medical negligence). There were also a few challenges brought under the Clinical Establishments Acts. These have been discussed in a separate report.

Supreme Court- Since the Supreme Court judgments often undertake overlapping discussions on the tests to attribute civil or criminal liability and the corresponding burden of proof, we thought it more appropriate to consider these holistically rather than categorising them into consumer or criminal cases.

Analysis

The following additional data points for all these cases were captured by manually reading the cases:

- Is the accused an individual or establishment? (Individual/ Establishment/ Both / State)
- Is the healthcare provider a private or a government entity? (Private / Government)
- Main issue decided by the court (open-ended)
- Keywords of issue (Medical negligence, overcharging, professional misconduct, etc)
- Nature of liability (consumer / MCA / tort/ CoI / CEA/criminal)
- Was the case decided on merits?
- Outcome (Liable / Not Liable / NA)
- Who was held liable? (eg: Hospital / doc / Both / State / NA)
- Reason for holding liable or evidence relied upon (open-ended)
- Nature of penalty (imprisonment/fine/ reimbursement/compensation/ suspension / damages etc)
- Quantum of the penalty? (open-ended)
- How was this quantum calculated? (open-ended)
- Any other direction (open ended)
- Name of legal test applied (if applicable)
- Was a landmark decision relied upon (Jacob Mathew/ VP Shantha/ Martin D'Souza / Nikhil Super Speciality/ Kunal Saha/ Spring Meadows/ Samira Kohli/Kusum Sharma)
- If yes, in what context? (open-ended)
- Additional comments/ notes

Limitations

1. Our data has been created using the very limited search words 'medical negligence'. It is possible that we have excluded other relevant cases which did not contain this specific phrase.
2. Our analysis involved reading each of the judgments in our dataset manually, both for filtering the relevant cases and for extracting relevant information. It is therefore possible that there may be few inaccuracies or human errors in collecting and analysing the data despite our best efforts to mitigate these.

Overall Limitations of the Study

- The study primarily focuses on the criminal and consumer litigation against healthcare providers as a means of ensuring accountability. Any other litigation that performs the same function has not been examined in this report. One exception to this is tortious claims of medical negligence which have been decided by the High Courts. These have been included in the study.
- The study only examines specific wrongs which have been alleged against the healthcare providers. For criminal cases, only offences under section 304A have been examined while at the High Court level, only cases containing the phrase 'medical negligence' have been studied. For consumer cases, our database was based on certain search terms. Therefore, it is possible that there are more cases against healthcare providers which have not been included in this study, although our sample suggests that the overwhelming proportion of such cases involve medical negligence as broadly understood by the courts.
- Our dataset has been gathered from three different sources - ecourts website, CONFONET and Manupatra. The scope of the information maintained by these platforms may vary making it difficult to compare the data.

Snapshot of the Data

Annex Table 1: Snapshot of the data on consumer cases included in the study

Institutions Covered	Consumer Forums	High Courts
Source	CONFONET	Manupatra
Years included	2006 - 2022	1992-2022
Scope	Select keywords like - Medical Negligence, Clinic, Doctor, Hospital, Medicine, Nursing, Patient, Surgery	All cases including 'medical negligence'
No. of cases	Sample taken from a total no. of 5996 cases with the following composition NCDRC - 69 State Forums - 114 District Forums - 177 Total - 360	13

Annex Table 2: Snapshot of data on criminal cases included in the study

Institutions Covered	District Courts	High Courts
Source	e-Courts portal	Manupatra
Years included	2010 - 2022	1992-2022
Scope	304-A IPC	All cases including 'medical negligence'
Excludes	Revision petitions, settlements, interim orders	Settlements, interim orders
No. of cases	1964-2022	226

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