explained in the three Judge Bench decision of this Court in Jacob Mathew vs. State of Punjab and Anr. (2005) 6 SCC 1. However, difficulties arise in the application of those general principles to specific cases.

31. For instance, in para 41 of the aforesaid decision it was observed :

> "The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence is what the law requires."

32. Now what is reasonable and what is unreasonable is a matter on which even experts may disagree. Also, they may disagree on what is a high level of care and what is a low level of care.

33. To give another example, in paragraph 12 to 16 of Jacob Mathew's case (Supra), it has been stated that simple negligence may result only in civil liability, but gross negligence or recklessness may result in criminal liability as well. For civil liability only damages can be imposed by the Court but for criminal liability the Doctor can also be sent to jail (apart from damages which may be imposed on him in a civil suit or by the Consumer Fora). However, what is simple negligence and what is gross negligence may be a matter of dispute even among experts.

34. The law, like medicine, is an inexact science. One cannot predict with certainty an outcome of many cases. It depends on the particular facts and circumstances of the case, and also the personal notions of the Judge concerned who is hearing the case. However, the broad and general legal principles relating to medical negligence need to be understood.

35. Before dealing with these principles two things have to be kept in mind : (1) Judges are not experts in medical science, rather they are lay men. This itself often makes it somewhat difficult for them to decide cases relating to medical negligence. Moreover, Judges have usually to rely on testimonies of other doctors which may not necessarily in all cases be objective, since like in all professions and services, doctors too sometimes have a tendency to support their own colleagues who are charged with medical negligence. The testimony may also be difficult to understand, particularly in complicated medical matters, for a layman in medical matters like a Judge; and (2) A balance has to be struck in such cases. While doctors who cause death or agony due to medical negligence should certainly be

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION
CIVIL APPEAL NO. 3541 OF 2002
Martin F. D'Souza .. Appellant
-versus-
Mohd. Ishfaq .. Respondent
J U D G M E N T
MARKANDEY KATJU, J.

1. This appeal against the judgment of the National Consumer Disputes Redressal Commission, New Delhi dated 22.3.2002 has been filed under Section 23 of the Consumer Protection Act, 1986.

2. Heard learned counsel for the parties and perused the record.

3. The brief facts of the case are narrated below :

4. In March 1991, the respondent who was suffering from chronic renal failure was referred by the Director, Health Services to the Nanavati Hospital, Mumbai for the purpose of a kidney transplant.

5. On or about 24.4.1991, the respondent reached Nanavati Hospital, Bombay and was under the treatment of the appellant Doctor. At that stage, the respondent was undergoing haemodialysis twice a week on account of chronic renal failure. Investigations were underway to find a suitable donor. The respondent wanted to be operated by Dr. Sonawala alone who was out of India from 1.6.1991 to 1.7.1991.

said injection.

I say that after 11th June, 1991, the said Mohd. Ishaq came to the hospital as an outdoor patient on 14th June, 17th June and 20th June, 1991 and did not make any complaint of any nature whatsoever with regard to his hearing faculties. On the contrary, he used to have conversation and used to respond to the same as an ordinary man. The said Mohd. Ishaq used to come to hospital on his own without the assistance or help of anybody and after the dialysis also he used to go on his own. Thus, until 20th June, 1991, the said Mohd. Ishaq had no problems either in hearing or in movement of the limbs or parts of his body or in lifting parts of his body or in walking."

106. From these deposition and affidavits it cannot be said that the appellant was negligent. In fact most of the doctors who have deposed or given their affidavits before the Commission have stated that the appellant was not negligent.

107. In his written statement filed before the National Commission the appellant has stated in paragraph 9 (q-r) as follows :

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

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

6. On 20.5.1991, the respondent approached the appellant Doctor. At the time, the respondent, who was suffering from high fever, did not want to be admitted to the Hospital despite the advice of the appellant. Hence, a broad spectrum antibiotic was prescribed to him.

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

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

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

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

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

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

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

13. On 5.6.1991, Amikacin injection was administered to the respondent for

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

13. On 5.6.1991, Amikacin injection was administered to the respondent for

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

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

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

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

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

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

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

20. On 7.7.1992, the respondent filed a complaint before the National Consumer Disputes Redressal Commission, New Delhi (being Original Petition

operates on someone for removing an organ for illegitimate trade.

42. There is a tendency to confuse a reasonable person with an error free person. An error of judgment may or may not be negligent. It depends on the nature of the error.

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

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

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

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

No.178 of 1992) claiming compensation of an amount of Rs.12,00,000/- as his hearing had been affected. The appellant filed his reply stating, inter alia, that there was no material brought on record by the respondent to show any co-relationship between the drugs prescribed and the state of his health. Rejoinder was filed by the respondent.

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

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

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

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

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

i) The appellant-Dr. M.F. D'Souza

(i) Removal of the wrong limb;

(ii) Performance of an operation on the wrong patient;

(iii) Giving injection of a drug to which the patient is allergic without looking into the out-patient card containing the warning;

(iv) Use of wrong gas during the course of an anaesthetic, etc.

73. From the aforementioned principles and decisions relating to medical negligence, with which we agree, it is evident that doctors and nursing homes/hospitals need not be unduly worried about the performance of their functions. The law is a watchdog, and not a bloodhound, and as long as doctors do their duty with reasonable care they will not be held liable even if their treatment was unsuccessful.

74. However, every doctor should, for his own interest, carefully read the Code of Medical Ethics which is part of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 issued by the Medical Council of India under Section 20A read with Section 3(m) of the Indian Medical Council Act. 1956.

75. Having mentioned the principles and some decisions relating to medical negligence (with which we respectfully agree), we may now consider whether the impugned judgment of the Commission is sustainable. In our opinion the judgment of the Commission cannot be sustained and deserves to be set aside.

76. The basic principle relating to the law of medical negligence is the Bolam Rule which has been quoted above. The test in fixing negligence is the standard of the ordinary skilled doctor exercising and professing to have that special skill, but a doctor need not possess the highest expert skill. Considering the facts of the case we cannot hold that the appellant was guilty of medical negligence.

77. The facts of the case reveal that the respondent was suffering from chronic renal failure and was undergoing haemodialysis twice a week on that account. He was suffering from high fever which remained between 101°-104°F. He refused to get admitted to hospital despite the advice of the appellant. The

ii) Dr. Danbar
iii) Dr. Upadhyay
iv) Mrs. Mukta Kalekar
v) Dr. Ashique Ali Rawal

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

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

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

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

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

30. The general principles on this subject have been lucidly and elaborately

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

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

65. In Dr. Suresh Gupta vs. Government of N.C.T. of Delhi and another AIR 2004 SC 4091, the appellant was a doctor accused under Section 304A IPC for causing death of his patient. The operation performed by him was for removing his nasal deformity. The Magistrate who charged the appellant stated in his judgment that the appellant while conducting the operation for removal of the nasal deformity gave incision in a wrong part and due to that blood seeped into the respiratory passage and because of that the patient collapsed and died. The High Court upheld the order of the Magistrate observing that adequate care was not taken to prevent seepage of blood resulting in asphyxia. The Supreme Court held that from the medical opinions adduced by the prosecution the cause of death was stated to be `not introducing a cuffed endotracheal tube of proper size as to prevent aspiration of blood from the wound in the respiratory passage.' The Supreme Court held that this act attributed to the doctor, even if accepted to be true, can be described as a negligent act as there was a lack of care and precaution. For this act of negligence he was held liable in a civil case but it cannot be described to be so reckless or grossly negligent as to make him liable in a criminal case. For conviction in a criminal case the negligence and rashness should be of such a high degree which can be described as totally apathetic towards the patient.

66. In Dr. Sr. Louie and Anr. vs. Smt. Kannolil Pathumma & Anr. the

explained in the three Judge Bench decision of this Court in Jacob Mathew vs. State of Punjab and Anr. (2005) 6 SCC 1. However, difficulties arise in the application of those general principles to specific cases.

31. For instance, in para 41 of the aforesaid decision it was observed :

"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence is what the law requires."

32. Now what is reasonable and what is unreasonable is a matter on which even experts may disagree. Also, they may disagree on what is a high level of care and what is a low level of care.

33. To give another example, in paragraph 12 to 16 of Jacob Mathew's case (Supra), it has been stated that simple negligence may result only in civil liability, but gross negligence or recklessness may result in criminal liability as well. For civil liability only damages can be imposed by the Court but for criminal liability the Doctor can also be sent to jail (apart from damages which may be imposed on him in a civil suit or by the Consumer Fora). However, what is simple negligence and what is gross negligence may be a matter of dispute even among experts.

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35. Before dealing with these principles two things have to be kept in mind :

(1) Judges are not experts in medical science, rather they are lay men. This itself often makes it somewhat difficult for them to decide cases relating to medical negligence. Moreover, Judges have usually to rely on testimonies of other doctors which may not necessarily in all cases be objective, since like in all professions and services, doctors too sometimes have a tendency to support their own colleagues who are charged with medical negligence. The testimony may also be difficult to understand, particularly in complicated medical matters, for a layman in medical matters like a Judge; and (2) A balance has to be struck in such cases. While doctors who cause death or agony due to medical negligence should certainly be

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penalized, it must also be remembered that like all professionals doctors too can make errors of judgment but if they are punished for this no doctor can practice his vocation with equanimity. Indiscriminate proceedings and decisions against doctors are counter productive and serve society no good. They inhibit the free exercise of judgment by a professional in a particular situation.

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

General Principles Relating to Medical Negligence

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

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

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

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

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

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

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would have prescribed different treatment or operated in a different way; nor is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men. Deviation from normal practice is not necessarily evidence of negligence. To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care."
(emphasis supplied)

40. Eckersley vs. Binnie (1988) 18 Con LR 1 summarized the Bolam test in the following words :

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

41. A medical practitioner is not liable to be held negligent simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. He would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field. For instance, he would be liable if he leaves a surgical gauze inside the patient after an operation vide Achutrao Haribhau Khodwa & others vs. State of Maharashtra & others, AIR 1996 SC 2377 or operates on the wrong part of the body, and he would be also criminally liable if he

Hence the appellant advised the respondent to further stay in the hospital for some time, but the respondent did not agree and he started shouting at the top of his voice and insisted to be discharged from the hospital on his own on 8.6.1991 at 9 a.m..

87. In view of his insistence the respondent was discharged from the hospital on his own on 8.6.1991 at 9 a.m.. The appellant suggested alternate day Haemodialysis but the respondent refused saying that he was staying too far away and could not come three times a week for Haemodialysis. In this situation, the appellant was left with no choice but to suggest Injection Amikacin (500 mg) twice a day in view of the respondent's infection and delicate condition and his refusal to visit the Haemodialysis facility on alternate dates. The appellant also suggested the following drugs under the supervision of the doctor when he would visit the dialysis unit:

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

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

89. On 11.6.1991 the respondent complained to the appellant of slight tinnitus or ringing in the ear. The appellant immediately reviewed the treatment on the discharge card in possession of the respondent and asked the said respondent and also asked his attendant i.e. his wife to stop Injection Amikacin and Cap. Augmantine verbally, and also marked 'X' on the discharge card in his own hand writing on 11.6.1991 i.e. 3 days after discharge. Hence, as per direction of the appellant the respondent should have stopped receiving Injection Amikacin after 10.6.1991, but on his own he kept on taking Amikacin Injections. The Discharge Card as per the respondent's complaint clearly shows that the said injection had

operates on someone for removing an organ for illegitimate trade.

42. There is a tendency to confuse a reasonable person with an error free person. An error of judgment may or may not be negligent. It depends on the nature of the error.

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

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

(emphasis supplied)

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

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

absolutely necessary and when no other drug is available. When asked whether Amikacin should be given to a patient with 10 days stretch, as was prescribed by the appellant in this case, Dr. Sareen replied that it was difficult to give an answer to that question because it depends entirely on the treating physician. Dr. Sareen has admitted that giving Amikacin injection twice a day for 14 days can cause nerve deafness which means losing one's hearing. No doubt, Dr. Sareen in his cross-examination stated that he would have prescribed the dose given to the respondent differently but he has not stated what would be the dose he would have prescribed.

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

102. In the affidavit of Dr. Raval of the Bombay Indian Inhabitant, who has been practicing in Urology for several years it is stated that the respondent had undergone a kidney transplant operation under Dr. Raval's supervision on 30th July 1991 at the Prince Alikhan Hospital, Bombay and he was discharged on 13th August, 1991. Dr. Raval has stated in his affidavit that during the time the respondent was under his care he had a free conversation in English and Urdu without the aid of interpreter and he did not complain of suffering any hearing problem until he was discharged in the middle of August 1991. An affidavit to the same effect has been given by Dr. Kirti L. Upadhyaya, of Bombay Indian Inhabitant, who is also a Nephrologist. He stated that the respondent did not complain of any hearing problem to him also.

103. An affidavit has also been filed by Dr. Sharad M. Sheth, of Bombay Indian Inhabitant who is also MD qualified in Nephrology. He also stated in paragraph 3 of his affidavit as follows:-

> "I state that in the circumstances of the case when Klebsiella Organism was found resistant to all powerful drugs inclusive of Augmentin with the exception of Amikacin any nephrologist of a reasonable standard of proficiency would have prescribed "Amikacin" drug in measured doses as a life saving

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

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

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

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

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

49. When a patient dies or suffers some mishap, there is a tendency to blame