* **IN THE HIGH COURT OF DELHI AT NEW DELHI**

% **Judgment reserved on: 17 August 2023**
**Judgment pronounced on: 31 August 2023**

\+ LPA 487/2019 and CM APPL. 33424/2019 (134 Days Delay)

KRISHAN LAL KUMAR ..... Appellant
Through: Mr. Rudro Chatterje, Mr. Jatin Teotia, Mr. Mohit Bangwal and Md. Tanvir, Advs.

versus

MEDICAL COUNCIL OF INDIA & ORS ..... Respondents
Through: Mr. T. Singh Dev, Ms. Anum Hussain, Mr. Abhijit Chakravarty, Mr. Tanishq Srivastava, Mr. Bhanu Gulati, Mr. Aabhaas Sukhramani and Ms. Ramnpreet Kaur, Advs. for R-1/MCI
Mr. Praveen Khattar, Adv. for R-2/Delhi Medical Council

**CORAM:**
**HON'BLE MR. JUSTICE YASHWANT VARMA**
**HON'BLE MR. JUSTICE DHARMESH SHARMA**

## J U D G M E N T

**DHARMESH SHARMA, J.**

1. The appellant has instituted this 'Letters Patent Appeal' in terms of Clause 10 of the Letters Patent of Lahore, as applicable to the Delhi High Court, read with Section 10 of the Delhi High Courts Act,

1996[1], against the impugned Judgment dated 06 February 2019, passed by the learned Single Judge of this Court, whereby a Writ Petition instituted by him bearing WP(C) No. 7097/2013 seeking Writ of Mandamus or any other writ or direction to quash the order dated 26 April 2013 passed by the respondent No.1 and also seeking disciplinary action against the respondent No.3 and for cancellation of his registration as Medical Practitioner or debar from his medical practice on account of negligence leading to the death of his wife, was dismissed.

**FACTUAL BACKGROUND:**

2. The appellant is about 80 years of age and he grieves that his wife about 67 year of age died due to medical negligence at the hands of respondent no. 3. It is stated that his wife had been suffering from 'Brain Tumor' and had been under medical treatment of respondent No.3 since 2003, who operated upon her for the first time on 03 November 2003; and thereafter she remained under his follow-up treatment. In 2008, she was again advised to undergo 'Tumor Excision Surgery' by the respondent No.3, and operated on 10 November 2008 and the follow-up treatment continued under his supervision. It is stated that the appellant with his wife went to the respondent No.3 on 28 April 2011 for regular quarterly check-up and his wife was advised to undergo surgery urgently by the respondent No.3 and heeding to his advice, the operation was performed on 07 May 2011 at the

[1] LPA

respondent No.4 Hospital but certain unexplained post-surgical complications ensued, and eventually his wife passed away on 31 May 2011.

3. The grievance of the appellant is that respondent No.3 had operated upon his wife without conducting a fresh MRI, and thus he lodged a complaint dated 07 June 2011 with the respondent No.4 Hospital and in response the respondent No.4 Hospital sent a letter dated 29 June 2011 to the appellant *inter alia* stating that '*all necessary investigations needed to assess the patient were done*' and his wife was posted for surgery after obtaining required clearances and obtaining the necessary consent. Not satisfied, the appellant sent a complaint dated 21 July 2011 to the Delhi Medical Council[2]/ respondent No.2 to initiate appropriate action against the respondent No.3 for medical negligence in the treatment of his wife resulting in her untimely death.

4. It is stated that as the DMC was unresponsive to his repeated reminders, he was constrained to prefer an application under the Right to Information Act, 2005[3] on 23 November 2011, in response to which the DMC vide letter dated 29 November 2011 informed him that his complaint was taken up for consideration before the Executive Committee of the DMC and it was directed that a specialist in the field of surgery be co-opted as an expert member and the matter would be taken up for further deliberation. The respondent No.3 was then called

[2] DMC
[3] RTI

upon by the DMC vide letter dated 26 December 2011 to submit his statement of defence in response to the complaint by the appellant, which was submitted by him on 09 January 2012 *inter alia* stating that the MRI test was not done considering the nature of tumor i.e. 'Meningioma being a gentle tumor which grows slowly over the years'; and that the patient was seriously ill, and a written and informed consent regarding the benefits & risks involved in the surgery was taken from the appellant, and only then was the patient cleared for surgery after consultation with the Physician, Anesthetist and Ophthalmologist.

5. Suffice to state that eventually the DMC passed an order dated 30 August 2012 holding that no case of medical negligence was made out against the respondent No.3 in the treatment of his wife, and the patient died due to '*known complications associated with surgery of such nature*'. The appellant sought information under the RTI seeking details of the expert advice on the basis of which the order dated 30 August 2012 was passed. The DMC replied vide letter dated 19 September 2012 *inter alia* to the effect that no expert opinion in the matter was available on the record. An appeal was preferred by the appellant before the respondent No.1/Medical Council of India[4], which was disposed of vide order dated 22 April 2013 whereby the Ethics Committee of the MCI concurred with the views/report of the DMC that there was no medical negligence on the part of the

[4] MCI

respondent No.3 in the treatment of appellant's wife. The impugned order dated 22 April 2013 passed by the MCI was assailed in the Writ Petition primarily on the grounds that information provided by the GB Pant Hospital and DDU Hospital in response to queries raised by the petitioner/appellant under the RTI categorically brought out that an MRI Scan was essential prior to an operation of the skull and in response to the query by the appellant as to whether MRI Scan of the skull done prior to six months of the operation was sufficient, it was unequivocally responded in 'the negative'; and secondly on the ground that the DMC passed the order dated 30 August 2012 without receiving any expert opinion and although the DMC had sought opinion of Dr. Daljeet Singh, Professor of Neurosurgery, Department of Neurosurgery, GP Pant Hospital but no separate opinion had been expressed by the said Doctor.

**IMPUGNED ORDER:**

6. In a nutshell, learned Single Judge found that the unscathed version of respondent No.3 before the Executive Committee of DMC as also before the MCI was that the patient was diagnosed with 'left Sphenoid wing Meningioma', and she had been under his follow up treatment for over seven years for recurrence of tumours on the same side and during one of her visits in 2010 she complained of symptoms of weakness in her right side of the body, slurring of speech, blurring of vision and bilateral hearing loss; and that MRI of the brain was conducted on his advice on 29 October 2010; and that the MRI suggested possibility of recurrence of 'mitotic etiology (meningioma)

at the same side'. It was represented by the respondent No.3 that although he had advised the patient to immediately undergo surgery, she approached him after a period of six months. It was further asserted by him that since the patient had been under his regular medical treatment, and thus knowing her medical condition, he did not feel the need for repeat CT scan/MRI scan before performing surgery upon her 07 May 2011.

7. Resultantly, learned Single Judge found that the appellant failed to demonstrate any flaw in the decision making process of the DMC/MCI in accepting such version of respondent n.3. It was further held that the responses on the RTI application received by the petitioner/appellant from other Hospitals were not conclusive in nature. Lastly, as regards the plea that the decision by the DMC was questionable inasmuch as the Executive Committee acted without seeking any opinion of an expert in Neurosurgery, it was found that the Executive Committee had decided to have a Specialist in the field of Neurosurgery by co-opting him/her as an expert member and accordingly Dr. Daljeet Singh, Professor Neurosurgery was co-opted as a part of the Executive Committee, and thus, there was no necessity of seeking a separate opinion by an expert. Hence, it was held that there was no ground for judicial review and the Writ Petition was held to be without any merit and same was dismissed.

**GROUNDS OF APPEAL**

8. The impugned Judgment passed by the learned Single Judge dated 26 July 2019 has been assailed on *ditto* grounds as were

canvassed in the Writ Petition. Reference has been invited to decision in the case of **Arun Kumar Manglik v. Chirayu Health and Medical Private Limited[5],** with learned counsel for the appellant submitting that in matters of medical negligence, the courts should defer readily to expert opinion and apply their own mind as to whether reasonable care and treatment was given to the patient; and that learned Single Judge completely overlooked the crucial standard procedure that mandatorily requires conducting an MRI before a brain surgery; and that the reports of DMC as also that of MCI were silent about necessity of conducting an MRI Scan before a brain surgery and it was apparent on the face of the record that an MRI conducted six months prior to the surgery could not have been relied upon; and that DMC as also the MCI had failed to appreciate in their reports that although patient was under treatment of respondent No.3 for more than 7½ years, yet he failed to 'adequately communicate' to the patient and her family about the probable risks associated with the surgery without conducting an MRI Scan, for which reference is invited to decision in **Samira Kohli v. Dr. Prabha Manchanda[6].** Lastly, that learned Single Judge has simply brushed aside the definite responses to the RTIs from two prominent government Hospitals of the city that MRI or CT Scan was absolutely essential before conducting a brain surgery and has not followed the theory of 'Bolam

[5] (2019) 7 SCC 401
[6] (2008) 2 SCC 1

Test', placing reliance on decision in **Montgomery v. Lanarkshire Health Board**[7]**.**

9. Reply has been filed on behalf of the respondent No.4 along with an affidavit of its Assistant General Manager (Legal) and the appeal is opposed *inter alia* asserting that merely if the Doctor could not save the patient, he or she cannot be made liable for medical negligence. Showcasing the peculiar facts and circumstances, it is reiterated that an MRI/CT Scan would not have made any difference to the outcome of the treatment as ultimately the patient died due to 'known complications associated with surgery of such nature' i.e., brain tumor.

## ANALYSIS AND REASONS FOR DECISION

10. We have given our thoughtful consideration to the submissions advanced by the learned counsels for the parties at the Bar, which were more or less in sync with the above-referred pleadings. We have gone through the entire record of the writ proceedings besides the impugned Judgment as also the relevant case law cited at the Bar.

11. The decision in the instant appeal delicately hinges on the core issue as to what 'standard of care' was expected from respondent No.3 before he proceeded to subject the deceased patient to surgery on 07 May 2011? The main plank of the plea of the appellant is that they were assured by the respondent No.3 that there was no threat to the life of his wife and they were persuaded to go for the surgery for removal of her tumor but despite their insistence, MRI was not done

[7] [2015] UKSC 11

prior to the scheduled surgery, and the report of which otherwise might have persuaded them not to give consent for the third surgery.

12. First things first, the documents relied upon by the parties clearly brings out that the deceased patient had been under the continuous medical treatment of respondent No.3 since the very beginning of the diagnosis of the tumor in the year 2003 and since then she had already been operated twice by him on 03 November 2003 and 10 November 2008. Further, the patient had been under follow up treatment of respondent No.3 and when she approached him sometimes in October, 2010, again an MRI scan was done on 29 October 2010 that clearly reported the possibility of recurrence of mitotic aetiology (meningioma). There is no denial to the effect that although respondent No.3 advised the patient for an immediate surgery in October, 2010 itself, she & her family did not adhere to the said advice.

13. However, they approached respondent no. 3 after a critical gap of six months, when it was found that the patient was exhibiting weakness in right upper & lower limbs, slurring of speech and also deviation of the face to the left side besides complaining of memory disturbance and forgetfulness apart from blurring of vision and bilateral hearing loss. She was admitted on 04 May 2011 at the hospital/respondent no. 4, and admittedly subjected to necessary pre-operation investigations and consultation with the Physician, Anesthetist and Ophthalmologist. The surgery for "Left Temporo-parietal osteoplastic craniotomy and decompression of recurrent space

occupying lesion" was performed on 07 May 2011. It is also borne out from the record that post operation, the patient was shifted to Intensive Care Unit and her medical condition was subjected to constant watch '24 x 7' inclusive of medication as per advice by a multi-disciplinary team of Doctors.

14. It would be expedient to reproduce the version of the respondent No.3 in his reply dated 09 January 2012 in response to the letter notice by the DMC dated 26 December 2011, which goes as under:-

> "3. A therapeutic lumbar drainage was done for Pseudomeningocele and samples were sent for investigation. The result of the test revealed no features of meningitis and the surgical pathology report revealed Meningiothelial Meningioma. The family and relatives were regularly informed of the clinical condition of the patient. A Thecoperitoneai shunt was planned on 20.05.2011. The patient, however, had vomiting and developed a spike of fever and high total leukocyte count. Her surgery was withheld and antibiotics were changed accordingly. The fever settled; Total Leucocytes Count decreased and the theco-peritoneal shunt was done on 23.05.2011 following which the pseudomeningocele completely subsided. The patient was started on oral soft diet and she remained stable.
> 4. However on 27.05.2011, the patient developed sudden onset of tachypnea, tachycardia, hypotension and excessive perspiration. She responded to fluid resuscitation and oxygen inhalation. Pulmonary embolism was suspected as the patient had had lower limb weakness and was bed ridden for long. Injection Clexane was started, investigations sent. However the same evening she again developed hypotension with decreased urine output, therefore, fluid resuscitation done again and patient was put on inotropic support. A cardiology consultation was sought and ECHO and other investigations were done. Echocardiography was suggestive of pulmonary thromboembolism (PTE). The family was informed about the clinical condition of the patient. The possible optimal treatment for PTE had already been started and this was communicated clearly to the family again. She later had

> paroxysmal atrial fibrillation and accordingly Cordarone was added. She remained critically ill and developed intermittent tachycardia and hypotension. Low molecular weight Heparin was changed to unfractionated Heparin and Injection Dobutamine were started. Despite all measures taken, the condition of the patient continued to deteriorate. She was put on mechanical ventilation and Noradrenalin infusion. The relatives of the patient were explained about guarded prognosis. The condition of the patient deteriorated further and despite all the resuscitative measures she succumbed to her illness at 3.44 p.m. on 31.05.2011."

15. Keeping at bay the medical terminologies, it is brought out that that the allegations levelled by the appellant as also the reply by the respondent No.3 were duly considered by the Executive Committee of the DMC in its report dated 30 August 2012, and the relevant extract of which is set out as under:-

> "The Executive Committee of Delhi, Medical Council examined a complaint of Shri K.L Kumar r/o. 2551, Hudson Lane, Kingsway Camp, Delhi - 110009 (referred hereinafter as the complainant),
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> alleging medical negligence on the part of Dr. S.K Sogani, in the treatment administered to complainant's wife late Savita Kumar (referred hereinafter as the patient) at Indraprastha Apollo Hospital, Sarita Vihar, Delhi-Mathura Road, New Delhi, résulting in her death on 31.5.2011.
>
> & the Executive Committee perused the complaint, written statement of Dr. S.K. Sogani and Medical Superintendent, Indraprastha Apollo Hospital, copy of medical records of Indraprastha Apollo Hospital and other documents on records.
>
> The Executive Committee noted that the patient late Savita Kumar was a case of recurrent meningioma operated twice before the final operation (third surgery), done on 7th May, 2011 at Indraprastha Apollo Hospital by Dr. S.K. Sogani. The patient was diagnosed as a case of recurrent left sphenoid wing meningioma and was taken up for surgery (Left Temporo-parietal osteoplastic craniotomy and decompression of recurrent space occupying lesion) as per accepted professional practices in such cases, under

informed consent which had detailed the complications associated with the surgical procedure.

After surgery, the patient developed pulmonar), embolism which was treated accordingly, unfortunately the patient succumbed to her ailments on 31st May, 2011.
It is further observed that as the M.RI had been done almost six months before the surgery, the explanation given by Dr. S.K. Sogani for not considering repeat M.R.I is found to be satisfactory in terms of management of the case.

In view of the observations made hereinabove, it is the decision of the Executive Committee that prima-facie no case of medical negligence is made out in the treatment administered to late Savita Kanwar at Indraprastha Apollo Hospital. The patient died due to the known complications associated with surgery of such nature, which in spite of being treated as per standard protocol, have grave prognosis/outcome."

16. On the appeal being filed by the appellant on 23 December 2012, the matter was considered by the Ethics Committee in its meeting held on 23 February 2013 and the following recommendation was approved by the Board of Governors at their meeting held on 22 April 2013:-

> "The Ethics Committee heard the deposition of both the parties in detail and after going through & reviewing all the relevant records &documents, the Ethics Committee observed that pre-operative MRI would hot have made any difference in the outcome of the treatment, however, there was a communication gap between the doctor and the patient. The Ethics Committee was of the view that there was no medical negligence on the part of Dr. S.K. Sogani, but advised the doctor that he should improve his communication with regards to doctor - patient relationship. Accordingly, the appeal is disposed off."

17. Without further ado, we are unable to find any merit in the plea by the appellant that decisions by the DMC followed by the MCI were flawed in any manner. At the cost of repetition, the patient had been

under continuous medical treatment of respondent No.3 for over seven years. It is pertinent to find that while considering the allegations levelled in the complaint on the issue of medical negligence, the Executive Committee of the DMC also nominated Dr. Daljeet Singh, Professor of Neurosurgery, Department of Neurosurgery, G.P. Pant Hospital, as an expert member and the record shows that the deliberations took place and after hearing the parties and considering the entire medical record, the aforesaid decision dated 30 August 2012 was arrived at. Both DMC as also the MCI did not find any 'standard protocol' that any MRI scan was mandated to be performed prior to performing the surgery upon the patient, particularly in view of the medical history and treatment being dealt exclusively by the respondent No.3. The ultimate finding that the patient died due to 'known complications associated with the surgery of such nature despite being treated as per the standard protocol', was also fraught with grave prognosis/outcome in the opinion of the DMC/MCI.

18. At the cost of repetition, an expert in the field of Neurosurgery was co-opted as a member of the Executive Committee of the DMC and the learned Single Judge rightly observed that the information obtained by the appellant pursuant to RTI queries from other Hospitals, that MRI was desirable prior to conducing the surgery in the nature of brain tumor, was general in nature and *de hors* any consideration of the medical history of the patient concerned. In reaching the aforesaid view, we deem it apposite to refer to the decision in the case of **Kusum Sharma v. Batra Hospital & Medical**

**Research Centre & Ors.**[8] It was a case where the appellants/legal heirs of the deceased patient sought compensation for medical negligence on the part of the attending doctors and the Hospital, which claim was dismissed by the National Consumer Disputes Redressal Forum[9] and a Special Leave Petition was filed before the Supreme Court of India. It was a case where, the patient had complained of abdominal pain and the CT Scan revealed a smooth surface mass in the left adrenal measuring 4.5 x 5 cms while the right side adrenal was normal. The patient underwent surgical operation for removal of abdominal tumor on 02 April 1990 and as the patient was under considerable pain, inconvenience and anxiety and the flow fluids did not stop, another surgery was carried out on 23 May 1990. Since in due course wounds were supposed to get healed inside and fluid was supposed to stop, the patient was discharged on 23 June 1990 and the patient ultimately died on 11 October 1990. However, in the interregnum the patient got himself treated at Modi Hospital, and later at AIIMS, and lastly admitted in Mahatma Gandhi Hospital at Jodhpur, whereat he was diagnosed with having post operative complications of adrenalectomy and gluteal abscess. The Supreme Court upheld the decision by the NCDRF dismissing the claim for medical negligence as it was established that excessive bleeding (haematemesis) had occurred due to stress ulceration and not due the damage to the stomach by a nasoduodenal tube. The Supreme Court

[8] (2010) 3 SCC 480
[9] NCDRF

examined plethora of Indian and foreign case law on the issue of medical negligence, and referred to Halsburys Law of England 4th edition Volume 26 –PP 17-18, wherein the term 'medical negligence' is explained as under:

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

19. Further, the Supreme Court then referred to the celebrated and oft cited judgment in **Bolam v. Friern Hospital Management Committee**[10], wherein McNair, L.J. observed as under:

> "(i) a doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art, merely because there is a body of such opinion that takes a contrary view. (*Bolam case* [(1957) 1 WLR 582 : (1957) 2 All ER 118] , WLR p. 587)
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> "The direction that, where there are two different schools of medical practice, both having recognition among practitioners, it is not negligent for a practitioner to follow one in preference to the other accords also with American law; see 70 *Corpus Juris Secundum* (1951) 952, 953, Para 44. Moreover, it seems that by American law a failure to warn the patient of dangers of treatment is not, of itself, negligence (*ibid*., 971, Para 48)." (All ER p.119 A-B)
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> McNair, L.J. also observed:
> Before I turn to that, I must explain what in law we mean by 'negligence'. In the ordinary case which does not involve any special skill, negligence in law means this: some failure to do some act which a reasonable man in the circumstances would do, or the

[10] [(1957) 1 WLR 582 : (1957) 2 All ER 118

> doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge it by the conduct of the man on the top of a Clapham omnibus. He is the ordinary man. **But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this man exercising and professing to have that special skill. … A man need not possess the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.** (WLR p. 586)
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> **{emphasis supplied}**

20. Further, the Supreme Court on conducting an exhaustive exposition of leading cases on medical negligence, both in our country and other countries especially the United Kingdom, enumerated the following principles for guidance:-

> "I. Negligence is the breach of a duty exercised by omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.
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> II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.
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> III. The medical professional is expected to bring a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.
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> IV. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

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

VI. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

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

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

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

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

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

21. Though we can wind up our discourse forthwith, since reference is invited by the learned counsel for the appellant to the decision in the case in ***Arun Kumar Manglik v. Chirayu Health and Medical Private***

***Limited (supra),*** we feel it to be our duty to dwell upon it for more clarity on the matters in issue. It was a case where the spouse of the petitioner was diagnosed with dengue fever and was placed on regime of administering intravenous fluids. She had a prior medical history of high morbidity, which included 'catheter ablation' and paroxysmal supra ventricular tachycardia" suggestive of cardiac complication and fell in the group of patient that required in-hospital management. In short, the Hospital authorities were found to be lacking in constantly monitoring the condition of the patient so much that the patient had been left unattended for long intervals, and since the hospital staff failed to monitor the blood pressure, she went into dengue shock syndrome and eventually died. The Supreme Court upheld the decision by the NCDRF that had set aside the decision of the MPSCRF[11] and awarded compensation. While reiterating the dictum on the subject of medical negligence propounded in the above referred decision in ***Kusum Sharma v. Batra Hospital (supra),*** it was observed that the decision in the case of ***Bolan v. Friern Hospital Management Committee (supra)*** has been subject of academic debate in India and in other jurisdictions as there is a school of thought that the 'Bolam Tests' fail to make a distinction between the ordinary skilled Doctor and a reasonably competent Doctor. It was observed that while the former places emphasis on the standards adopted by the profession, the latter denotes that negligence is concerned with departure from

[11] MP State Consumer Redressal Forum

what ought to have been done in the circumstances and may be measured by reference to the hypothetical 'reasonable doctor'. Reference was invited to few foreign judgments as also one earlier decision by the Supreme Court, and it would expedient to re-produce the relevant discourse for a better understanding of the subject. Reference was invited to decision in **Maynard v. West Midland Regional Health Authority**[12], where Lord Scarman held thus: (All ER p. 638 E-F):

> **"39** "A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that there was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances."
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> **40.** In **Hucks v. Cole** [*Hucks* v. *Cole*, (1968) 118 New LJ 469 (CA)] , the Court of Appeal found the defendant guilty of medical negligence. Sachs, LJ held thus:
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> "Where the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then however small the risk the courts must anxiously examine that lacuna, particularly if the risk can be easily and inexpensively avoided. If the court finds on an analysis of the reasons given for not taking those precautions that in the light of current professional knowledge there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact, and where necessary to state that it constitutes negligence."
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> **41.** In **Bolitho v. City and Hackney Health Authority** [*Bolitho* v. *City and Hackney Health Authority*, 1998 AC 232 : (1997) 3 WLR 1151 : (1997) 4 All ER 771 (HL)] , the House of Lords held that the course adopted by the medical practitioner must stand a test to reason : (AC pp. 241 G-H & 242 A-B)

[12] (1984) 1 WLR 634: (1985) 1 ALL ER 635 (HL)

" … in my view, 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 genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In *Bolam case* [*Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582] itself, McNair, J. stated that the defendant had to have acted in accordance with the practice accepted as proper by a " [**Ed.** : The words between two asterisks are emphasised in the original.] *responsible* [**Ed.** : The words between two asterisks are emphasised in the original.] body of medical men". Later, at p. 588, he referred to "a standard of practice recognised as proper by a competent [**Ed.** : The words between two asterisks are emphasised in the original.] *reasonable* [**Ed.** : The words between two asterisks are emphasised in the original.] body of opinion". Again, in the passage which I have cited from *Maynard case* [*Maynard* v. *West Midlands Regional Health Authority*, (1984) 1 WLR 634 : (1985) 1 All ER 635 (HL)] , Lord Scarman refers to a "respectable" body of professional opinion. *The use of these adjectives—responsible, reasonable and respectable—all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis*. In particular in cases involving, as they so often do, the weighing of risks against benefits, **the Judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter**."

Granting due deference to the profession of medical practitioners, Lord Browne-Wilkinson held that it is only in a "rare case" when professional opinion is not capable of "withstanding logical analysis", that the Judge may hold that it is not reasonable or responsible : (AC p. 243 A-E)

"These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the Judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the

field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. ***But if, in a rare case, 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.***

*I emphasise that in my view, it will very seldom be right for a Judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable*. The assessment of medical risks and benefits is a matter of clinical judgment which a Judge would not normally be able to make without expert evidence. As the quotation [*Maynard* v. *West Midlands Regional Health Authority*, (1984) 1 WLR 634 : (1985) 1 All ER 635 (HL)] from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the Judge to prefer one of two views both of which are capable of being logically supported. **It is only where a Judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed."**

**42.** Closer home, in **V. Kishan Rao v. Nikhil Super Speciality Hospital** [*V. Kishan Rao* v. *Nikhil Super Speciality Hospital*, (2010) 5 SCC 513 : (2010) 2 SCC (Civ) 460] , a two-Judge Bench of this Court highlighted the shortcomings of the *Bolam* [*Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582] test : (SCC pp. 523-24, paras 23-25):

"*23*. Even though *Bolam* [*Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582] test was accepted by this Court as providing the standard norms in cases of medical negligence, in the country of its origin, it is questioned on various grounds. It has been found that the inherent danger in *Bolam* [*Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582] **test is that if the courts defer too readily to expert evidence medical standards would obviously decline.** Michael Jones in his treatise on *Medical Negligence* (Sweet and Maxwell), 4th Edn., 2008 criticised the *Bolam* [*Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582] test as it opts for the lowest common denominator. The learned author noted that **opinion was gaining ground in England that** *Bolam* [*Bolam* v. *Friern Hospital*

*Management Committee*, (1957) 1 WLR 582] **test should be restricted to those cases where an adverse result follows a course of treatment which has been intentional and has been shown to benefit other patients previously.** This should not be extended to certain types of medical accidents merely on the basis of how common they are. It is felt "to do this would set us on the slippery slope of excusing carelessness when it happens often enough" (see Michael Jones on *Medical Negligence*, para 3-039 at p. 246).

24. With the coming into effect of the Human Rights Act, 1998 from 2-10-2000 in England, the State's obligations under the European Convention on Human Rights (ECHR) are justiciable in the domestic courts of England. Article 2 of the Human Rights Act, 1998 reads as under:

> '**2.** Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.'

25. Even though *Bolam* [*Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582] test "has not been uprooted" it has come under some criticism as has been noted in Jackson & Powell on *Professional Negligence* (Sweet and Maxwell), 5th Edn., 2002. The learned authors have noted (see para 7-047 at p. 200 in *Professional Negligence*) that there is an argument to the effect that *Bolam* [*Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582] test is inconsistent with the right to life unless the domestic courts construe that the requirement to take reasonable care is equivalent with the requirement of making adequate provision for medical care. *In the context of such jurisprudential thinking in England, time has come for this Court also to reconsider the parameters set down in Bolam [Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582] test as a guide to decide cases on medical negligence and specially in view of Article 21 of our Constitution which encompasses within its guarantee, a right to medical treatment and medical care."* **(emphasis supplied)**

22. In the light of the aforesaid propositions of law, reverting back to the instant case, we find that respondent No.3 was an expert

medical practitioner, a neurosurgeon handling critical surgeries to deal with brain tumors. He was indeed expected to exercise reasonable standard of care commensurating with his medical knowledge and experience, applying his skill deal with the medical condition of the patient based on her long medical history. We find that there is nothing to discern that he failed to exercise reasonable medical skill as might have otherwise been done by other expert professionals in the field. Hence, the observations by the learned Single Judge that the proceedings before the DMC/MCI regarding medical negligence were in the nature of 'peer review', is not flawed. Resultantly, the observation that the question in the Writ Petition was only to the extent as to whether decision making process adopted by the peers was questionable in any manner, does not call for any interference.

23. We are afraid the appellant is on slippery slope since it has failed to establish any flawed approach in the decision making process or for that matter the impugned decisions that were arrived at by the Executive Committee of the DMC as also of the MCI. We are inclined to hold that 'the expert body of medical men' in the Executive Committee of the DMC and later MCI by all means directed their minds to the question of comparative risks and benefits, and reached a reasonable and defensible conclusion on the matter. We understand the pain and agony of the appellant who, unfortunate as it must look, lost his life time companion in his senior years. However, the crux of the matter is that in the peculiar factual narrative of this case, there is no material to discern that pre-operative MRI scan would have made

any difference in the outcome of the treatment. As substantiated by the DMC/MCI, respondent No.3 knew the condition of the patient and took a reasonably calculated decision to perform surgery upon her and ultimately the patient died of post-surgery complications.

24. In view of the aforesaid discussion, we find that the present appeal is devoid of any merit and same is dismissed. The pending application also stands disposed of.

**YASHWANT VARMA, J.**

**DHARMESH SHARMA, J.**

**AUGUST 31, 2023**
*Sadique*