"MEDICAL NEGLIGENCE: ESTABLISHING DUTY AND THE STANDARD OF CARE AND VIEWING THE EXTENT OF THE ROLE CONSENT PLAYS ALONG WITH THE DOCTRINE OF *'RES IPSA LOQUITUR'*"

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INTRODUCTION: A RESEARCH IN LAW OF TORTS

Medical negligence is a failure with respect to the duty owed by the medical practitioner to the patient. The failure could be as a result of actual 'breach' of duty or sheer incompetence. Since there is a degree of professional care owed to the patient and necessarily there is a presumption of competence of the medical practitioner, therefore, when the same is violated in any sense the patient can seek redress and it is for this very scenario that the concept of medical negligence comes into play. Medical negligence may involve, one or more of the following, a failure on the part of the medical practitioner for a negligent act or omission that may cause and injury to the patient, doctors being remiss in the conduct of the operation[1]; the same yardstick may apply to the hospital as well with respect to injury, treatment, after care and health management. The test established way back in 1957 under the English Tort law, popularly called the *Bolam* test, lays down a test that the medical practitioner must have ordinary skill and competence and need not possess the highest skill but he must reach the standard of a responsible body of medical opinion, then he is not negligent[2].

The legal redressal of these claims require remedies under tort law, criminal law (as an IPC offence) and as a failure / deficiency of 'service' under the Consumer Protection Act, 1986. The entire body of law on medical negligence and compensatory measures in India hinges on this.

In order to give a standard definition, it can be said-

[1] Nizam's Institute of Medical Sciences v. P.S.Dhananka; (2009) 6 SCC 1
[2] Bolam v. Friern Hospital Management Committee (1957) 1 WLR 582

"*An act or omission (failure to act) by a medical professional that deviates from the accepted medical standard of care*."[3]

It is important to state that medical negligence does not necessitate an injury, a simple deviation from the medical standard is sufficient to establish liability. Societal considerations require doctors to take into account the appropriate standard which comes not exclusively from their peers and other reasonable professional standards. However, ordinarily injury/death trigger litigation and fastening of liability of medical negligence, leading to compensation and other penal consequences. The first step in this scenario is to establish the duty of care. It must also be noted that the medical profession begs a certain standard of skill and knowledge, therefore the degree of care in the cases of medical negligence is often high and must be taken into account while passing a judgment.

Even after the establishment of a duty of care what is imperative is that the circumstances and the amount of risk involved in each of the individual cases must be taken into account. Therefore the paper aims to link the extent of current doctrines (example-Res Ipsa Loquitur[4]) to the medical profession. It is also noted that the medical profession is still evolving and the various developments which take place must not be used unreasonably and unnecessarily to harass medical professionals. It is on these very lines where the role of expert opinion and quantum of compensation also come into consideration and a reasonable mechanism for their determination needs to be devised.

A DEFINITIONAL PERSPECTIVE

Medical negligence is mainly the improper or negligent treatment of a patient by a health care professional. It occurs when the medical practitioner deviates from the established "standard of care" in the treatment of a patient. The "standard of care" is **defined** as what a reasonably prudent **medical** practitioner would or would not do under similar circumstances.[5]

[3] Goguen, J.D. David. "Medical Negligence: The Law Explained." AllLaw.com, www.alllaw.com/articles/nolo/medical-malpractice/negligence.html.
[4] Res ipsa loquitur-"the thing speaks for itself"
[5] Pandit, M S. "Medical Negligence-Coverage of the Profession." *NCBI*, US National Library of Medicine, www.ncbi.nlm.nih.gov/pmc/articles/PMC2779963/.

The said standard of the care is based on the nature of the profession. For a surgeon or anesthetist, it will be determined by the established standard of an average practitioner in the field while in case of specialists, a higher threshold will be required to be met. The three-part test is usually used to establish medical negligence with various factors influencing the actual outcome.

ESTABLISHMENT OF DUTY OF CARE

The relationship between a medical practitioner and a patient is a special one, it is governed by established moral and ethical obligations. From a definitional standpoint it can be said that-Reasonable degree of care and skill needs to be exercised on part of the practitioner. The duty of care in medical negligence takes the following forms.

a. Duty of care in deciding whether to undertake the case- If a medical practitioner undertakes a case there begins to exist a duty on his part to devote his complete skill to the patient and act in a completely bona fide manner.
b. Duty of care in deciding what treatment to give-The treatment given to a patient cannot be subjective or arbitrary in any manner. Apart from raising the question on the patient's consent, it also involves the doctor in establishing the 'reasonable standard' and there are certain circumstances where the practitioner cannot claim that he exercised his complete set of skills regardless of the outcome.
c. Duty of care in the administration of that treatment- When a particular practitioner takes on the treatment of a patient, there are several facets to be considered. The major one is whether the patient is in a condition to actually give consent for the treatment and if they are actually willing to take the treatment. While administering the treatment the practitioner has to take utmost care and again establish and attain the reasonable standard.

In order to establish negligence a three stage test is used-

1. A person is owed a duty of care
2. It is established that there is a breach of the duty
3. Harm which is legally recognized is caused as a direct consequence of the breach of that duty[6]

[6] Bryden, Daniele, and Ian Storey. "Duty of Care and Medical Negligence | Continuing Education in Anaesthesia Critical Care & Pain | Oxford Academic." *OUP Academic*,

At this juncture it is also important to note that a view has emerged that any patient encountered in professional environment is owed a duty of care. This implies that apart from the doctor all the members of the medical establishment owe a duty of care. However, this view has not been recognized by any medical authority. The following are certain conditions developed under prevailing circumstances on the basis of which the paper further attempts to explore the duty of care owed to the patients.

THE LIVING WILL

The living will be primarily an established process of advanced decision making by the patient which allows the patient who is an adult to refuse any medical treatment at a particular time in the future. The basis of this doctrine is that the said person may not have the mental capacity at that point in time to take an informed decision to consent or refuse the treatment at that later date. These Advanced Notices are usually used by people who suffer a predictable medical condition that may anticipate such a medical condition. The major question that may arise is- If a person has set out an Advanced Notice to refuse medical treatment, or a line of expected treatment, in the future would then the doctor still be liable for any mishap arising from the existing treatment given to the patient up till that point of time as the patient would not be in a position to give any further consent or express a refusal and the doctor is bound to rely on the Advanced Notice to discontinue further treatment as anticipated.

The major *Kerrie Wooltorton*[7] case in which the court held that the doctors were not liable for letting a girl die on her own free will based on the living will.

This clearly indicates that the doctors, though bound by the living will (which may come into effect at a later date), continue to remain bound by their duty to provide for appropriate medical care until the patient reaches the stage where his medical condition may be such that though he may not be in a position to give consent or

Oxford University Press, 19 June 2011, academic.oup.com/bjaed/article/11/4/124/266921/Duty-of-care-and-medical-negligence.

[7] This was an English case where the patient Kerrie Wool Torton had knowingly consumed ethylene glycol and died due to its toxicity. According to her, the purpose of calling the ambulance was not a cry to be saved, as she was aware of the ill effects of the toxic substance consumed, but a desire to die comfortably.

refuse and the doctor but as per his living will he would refuse medical treatment. In the case of India medical jurisprudence has not reached this stage of development but a sort of beginning on this debate was made with the development of law on passive euthanasia in the case of *Aruna Ramachandra Shanbaug*[8]. This decision was based on the Constitution Bench decision in *Gian Kaur*[9] that had upheld the "right to live with dignity" under Article 21 to be inclusive of "right to die with dignity"., and therefore, arrived at the conclusion of for the validity of euthanasia be it active or passive, while concluding that euthanasia in India can be allowed only through a valid legislation. However, this issue has now been referred to a larger bench in the matter of Common Cause[10] due to the observations rendered by the Supreme Court of India in the matter of *Aruna Shanbaug* where the Court having initially held that euthanasia in India can be allowed only through a valid legislation, thereafter went on to contradict its own interpretation in reading the case *Gian Kaur* that although the Supreme Court approved the view taken in *Airedale*[11] it did not clarify who can decide whether life support should be discontinued in the case of an incompetent person e.g. a person in coma or PVS (persistent vegetative state) and therefore was inconsistent in its interpretation. A mere reference in the verdict cannot be construed to mean that the Constitution Bench in *Gian Kaur* approved the opinion of the House of Lords in the case of *Airedale*. Therefore, the question of a living will is still open and under consideration before the Supreme Court. Therefore, on the outset it can be said that medical practitioners are not absolved of the duty of care due to the presence of a living will.

THE CASE OF MINORS

In the case of minors, it can be said that the parents of the minor on his behalf would be competent to refuse or accept the treatment. The major question to be answered is that whether the parent's decision makes the doctor owe a duty of care to the minor. The problem arises that if the parents refuse medical treatment in a certain situation and the child suffers as a result, question that would perhaps arise is whether the doctors continue to owe a duty of care to the child. The current practice is that in case of a mishap while treating a minor, the first compensation paid is to the people who are considered to have suffered a loss, meaning thereby,

[8] Aruna Ramachandra Shanbaug v. U.O.I. (2011) 4 SCC 454
[9] Gian Kaur v. State of Punjab (1996) 2 SCC 648
[10] Common Cause v. U.O.I. (2014) 5 SCC 338
[11] Airedale N.H.S. Trust v. Bland (1993) 1 All ER 821

the compensation is paid to the parents/guardians. The question remains whether it can be said that a medical practitioner owes a duty of care to the minor through the person acting on behalf of the minor. This question is however, of pure academic value and debate, without any authoritative ruling by the Indian Supreme Court or in the absence of a legislation governing the field. Decisions in the case of minors are ordinarily within the purview of the natural parent or guardian and legislation does exist to that effect, but to stretch the same to 'right to die' or a 'living will' which encompasses the interpretation of the basket of Fundamental Rights, more particularly the interpretation with respect to the right to life under Article 21 is yet a grey area.

THE CASE OF UNCONSCIOUS CASUALTY

In such a circumstance where there is an unconscious patient there arises a set of circumstances which follow: -

1. In the case of accident cases and unconscious patients the medical practitioner is under an obligation **to treat** the casualty[12]. The Supreme Court has held the obligation extends to private doctors as well, apart from Government medical facilities. The validity of this condition was upheld in *Parmanand Katara v. U.O.I*

2. This is a lifesaving procedure which is **in the best interest of the casualty**.[13]

In this scenario it has to be understood that if practitioner is conducting his practice in accordance with the existing norm in that current practice then there may not exist a duty of care. In case he deviates from that said norm then a duty of care may follow. For example- it is common practice to treat a victim of spinal injury while the victim is lying on his back, therefore if the doctor treats the unconscious medical patient not while the patient is lying on the back and a mishap occurs then a duty of care is owed by the medical practitioner.

ESTABLISHMENT OF THE STANDARD OF CARE

The 'Reasonable Standard' can be said to be the degree of skill and care which an ordinary medical practitioner in the course of his practice is expected to perform.

[12] Parmanand Katara v. U.O.I. (1989) 4 SCC 286

[13] "Duty of Care and The Law." *REAL First Aid*, www.realfirstaid.co.uk/dutyofcare/.

It implies doing those set of actions which the ordinary practitioner is expected to do as per his medical training.[14] The first problematic area arises as the standard of care is also alternatively described as the customary practices of the average physician, which means all actions / practice(s) what an average physician might generally perform in similar circumstances. The conflict arises as the customary practices are taken to be against the standard of a reasonable physician.

Customary Practices versus Reasonableness Standard

To solve the conflict a clear distinction needs to be made. The 'Reasonableness Standard' implies the general negligence standard. It presupposes that medical treatment can be ideal, that the perfect care can be given. The 'Customary Practices' Standard stems from the realisation that medical treatment cannot be ideal. There is a certain degree of risk in every scenario, and if medical treatment is presupposed to be perfect then every complication would be attributed to medical negligence. Example- While administering anaesthesia there is a certain degree of risk which no medical practitioner can avoid. The liability of the practitioner in such a case is limited only to the proper administration; any mishap thereafter cannot be attributed to him. Thus, to conclude it can be said that the standard of care is based on the customary practices of the average physician, it ensures that patients do not bring a case of medical negligence for anything less than full recovery.

External Factors Relevant to the Standard of Care

In order to establish the standard of care certain factors which are external to the defendant: -[15]

1. The Social Utility of the Act- At times the practitioner may avoid doing an act which may have precedence with customary practice for the very purpose that not doing that act would be in accordance with established social norms of society.
2. Emergencies- Particularly in cases involving accident victims at times the likelihood and seriousness of harm cannot be determined accurately. In such situations professional ethics may dictate to perform practices according to the

[14] Goguen, J.D. David. "What Is the Medical Standard of Care?" *AllLaw.com*, www.alllaw.com/articles/nolo/medical-malpractice/standard-of-care.html.
[15] **John Murphy**, Street on Torts- Negligent Invasions of Interest, Pg 310

established norm and not allow major deviations. However, minor inaccuracies may exist.

The Bolam Test

Another way of establishing the standard of care is by using the Bolam Test. It originated out of a jury hearing in the case of *Bolam v Friern Hospital Management Committee*[16]. In the case Mr Bolam had approached Friern Hospital to undergo electroconvulsive therapy and before the therapy there was no muscle relaxant given to him and he was not restrained either which led to him suffering fractures and other serious injuries, he brought a suit of medical negligence stating that the hospital was negligent for

1. Not issuing relaxants
2. Not restraining him
3. Not warning him about the risks involved

It was held that that the Friern Hospital was not liable as the doctors were operating according to established practice but however acknowledged that medical practitioners might change their practice when a whole substantial medical opinion conveys to do so and not carry out the outdated practice for the sole reason that it was established. The Bolam Test thus started being used for every all cases of medical negligence comprising of the general practice rule. It has been held in various cases some which are cited below:

• Maynard v West Midlands Regional Health Authority - The issue was of incorrect diagnosis.

• Whitehouse v Jordan - The issue was of incorrect treatment.
• Sidaway v Bethlem Royal Hospital Governor s – The issue was of disclosure of information and consent.

The Conflict involved in the Bolam Test

It has been opined that the test is one which is descriptive and favours the defendant. In usual cases the test of negligence is normative in nature. However,

[16] Bolam v. Friern Hospital Management Committee (1957) 1 WLR 582

the Bolam Test makes it difficult for the plaintiff to prove the actual case of medical negligence.[17]

The Validity of the Bolam Test

It is important to view the various aspects of the Bolam Test in accordance to test its validity.

1. It says that the general practices of the community are determined by a 'responsible body' of medical experts. The very concept of the responsible body is subjective there is no clarity as to who comprises the responsible body and how valid their claims are. Moreover, this creates further vagueness when multiple lines of treatment are available and discretionary powers needs to be exercised by the doctors.

2. With the increasing human rights movement, the patient rights ambit is also increasing and now it is opined that all facts relevant to the treatment are to be disclosed regardless of their significance.

In Roger v Whitaker, it was not disclosed to the patient a certain risk to the eye. It was proven that this risk was 1 in 14000 yet the medical authorities were held liable for the sole reason the risk was not revealed to the patient.

Therefore, it is concluded that the Bolam Test in light of the above grounds may not be valid in the current scenario and should be replaced by the 'Prudent Patient' test which states that the patient should be made aware of all risks involved, in all circumstances. Only then can the reasonable standard be established. Therefore, it is established that a medical practitioner cannot be held liable if he is acting according to an established practice merely because a certain body of opinion exists which has a contrary view.

The liability of the practitioner must be established by viewing the customary standards along with the relevant social utility of the acts in the prevailing circumstances.

[17] Jones, J Warren. "Law & Ethics: The Healthcare Professional and the Bolam Test."*Nature News*, Nature Publishing Group, 11 Mar. 2000, www.nature.com/bdj/journal/v188/n5/full/4800441a.html?foxtrotcallback=true.

THE ROLE OF CONSENT

In the entire arena of medical treatment there exists a duty to obtain prior consent of the patient before conducting the treatment, both for ethical and legal purposes

Consent can be given in various ways[18]:-

a. Express Consent: It is the most basic form and can be both oral and in writing, though the written consent may have a superior evidentiary value
b. Implied Consent: This refers to consent which may be implied by the patient
c. Tacit Consent: this consent refers to implied consent which is understood without being stated
d. Surrogate consent: This consent refers to consent given in place of the original patient's consent. It usually refers to the consent of family members approved by two medical practitioners.
e. Advance Consent-This refers to the consent given by the patient in advance
f. Proxy Consent-Refers to consent given by an authorised person

Apart from these various ways of giving consent it is also imperative to understand that 'Informed Consent' overrules all the other forms of consent and is only obtained after explaining all possible risks and side-effects. What the paper seeks to address is whether the importance of informed consent actually make the consent obtained superior and allow the establishment of a greater liability than other forms of consent.

The Areas of Conflict with regard to Informed Consent:

1. In the absence of special circumstances, a patient may not undergo treatment without informed consent. There is no set standard to determine the 'special circumstances'[19]
2. Informed consent may be hard to determine as the average patient's ignorance of medical language needs to be taken into account

[18]Nandimath, Omprakash V. "Consent and Medical Treatment: The Legal Paradigm in India." Indian Journal of Urology: IJU : Journal of the Urological Society of India, Medknow Publications, 2009, www.ncbi.nlm.nih.gov/pmc/articles/PMC2779959/

[19] Goguen, J.D. updated by David. "From Lack of 'Consent' to Patient Injury and a Medical Malpractice Lawsuit." *AllLaw.com*,www.alllaw.com/articles/nolo/medical-malpractice/lack-consent-patient-injury-lawsuit.html.

3. The doctor along with the risks must disclose the alternative methods of treatment. This must be done regardless if this is the best practice followed
4. At times courts are reluctant to create new paradigms and therefore stick to the 'professional standard'. The problem is that it greatly violates the patient's right to self determination

Establishing Nexus of Professional Standard

It is usually assumed that the duty to obtain informed consent is through custom which is followed in the profession. However, it is seen that custom cannot act as a defence in medical negligence. Therefore, it is proposed that the 'Professional Standard" is determined under two conditions:

1. Taking into account the circumstances of the particular situation, the medical profession has the ability to determine its own standard. The case of *Helling v. Carey*[20] *in which the patient brought a case of medical negligence against her* ophthalmologist for the loss of eyesight on account of glaucoma serves as an important example. Initially it was held that the chances of a patient suffering from glaucoma were very remote and it was not to test the patients under the age of 40 with tonometry but later it was held that the test was harmless and inexpensive and the patient should have been made to undergo it. Thus, no informed consent was obtained from the patient. Therefore, regardless of their existing a customary practice the profession had the ability to determine its own standard.
2. The practitioner is allowed a degree of discretion in the cases of absolute inability of disclosure. Usually in cases of extreme sensitivity and in cases where said information cannot be revealed due to public interest this paradigm may apply. The amount of discretion allowed will be governed by ethical standards of the public.
3. In case any complication in the scenario where informed consent has not been obtained by the patient, the practitioner has the burden to prove the immateriality of the risk and reason for lesser disclosure.

The Basis of the Proposed Standard

[20] Helling v. Carey, Supreme Court of Washington, 519 P.2d 981 (1974)

Fundamental Fairness:

a. In the case where there is no problem of consent on part of the patient, the doctor need only be liable for harm that accrued from his negligence. With taking into account the circumstances, the onus will completely be on the patient to choose the amount of risks regardless of whether it is an irrational choice. If a doctor operates under the 'expert knows best' doctrine, he would be liable.
b. It would shift the burden of proof from the patient to the practitioner. The patient's right to self-determination would not be violated.
c. There would be no need to determine the professional standard through custom or expert testimony, it would only act as a defence if the defendant proves that it is reasonable.

Thus, it is established that informed consent cannot be obtained only through the custom standard as there exists no streamlined community standard and expert testimony cannot be relied on in changing circumstances. The new mechanism would restrict their use and allow patients to exercise their right of self-determination and not make the medical practitioners liable for acts beyond the ambit of medical negligence.

RES IPSA LOQUITUR

This doctrine emphasise the prima facie aspect, it attempts to establish a clear case that the thing speaks for itself. The breach of duty is at first glance seen to be one as a deviation from the norm which an ordinary practitioner should keep. It is mainly an evidential principle which assists the claimant especially in cases of gross medical negligence. The important aspects which must be noted and which also cause experts to question the validity of this doctrine are[21]:

1. One is assumed to be negligent if he had **exclusive control** of the whatever caused the injury
2. If the above condition is established there is **no requirement for evidence**

[21] Gurnani, Neerja. "Medical Negligence." *Academike (ISSN: 2349-9796)*, 25 Nov. 2015, www.lawctopus.com/academike/medical-negligence/.

It must also be noted that in medical negligence a case of *Res Ipsa Loquitur* can be made when certain conditions are established which are; -

a. The patient suffers an injury that is not an expected complication of medical care;
b. The injury does not normally occur unless someone has been negligent
c. The defendant was responsible for the patient's well-being at the time of the injury.

The doctrine in itself is not a flawed one but the conflict arises in the strategic value it gives to the plaintiff as it does not require an expert to testify regarding the proper standard of care. This has led plaintiffs to bring a case of Res Ipsa Loquitur whenever expert testimony is unavailable to establish the standard of care. Their position is further strengthened in the case of *V.Kishan Rao Vs Nikhil Super Speciality Hospital & Anr*[22] which has provided a settled law that each and every case of "medical negligence" does not require Expert Opinion. Expert opinion is required only when a case is complicated enough warranting an expert opinion or facts of a case are such that the forum cannot resolve an issue without expert's evidence. Each case has to be judged by its own facts. There may be simple cases where expert evidence is not required. In such cases where expert evidence is not required the plaintiff attains a stronger position.

It is probably the reason that many states have limited the use of the doctrine to only the most obvious claims. Example- leaving a foreign substance in a patient's body, etc. In all the remaining cases, the plaintiff must present expert testimony as to standard of care and its breach. This is what leads us to the conflict of accepting this doctrine in the arena of medical negligence.

The Major Conflict

The most difficult part of a medical malpractice case is the proving of negligence especially since the defendants are the ones who handle the patient's medical records and write the summaries and observations. Further the defendant is sometimes the only one who was present on the ground and knows what actually occurred at the time the alleged medical negligence happened. The most knowledgeable expert medical witness will have their hands full in examining the evidence and figuring out what could have actually transpired in terms of the care

[22] V.Kishan Rao Vs Nikhil Super Speciality Hospital & Anr (2010) 5 SCC 513

given to the patient, and then convincing the Court as to what *should* have happened in the given circumstances.

Medical negligence can be invoked by a patient in the following conditions:

- The patient is injured as the result of a medical procedure, and
- The patient does not know exactly what caused his or her injury,
- But it is the type of injury that would not have ordinarily occurred but for negligence on the part of the health care provider.

It is the interpretation of the third condition which in many cases helps tip the balance in favour of the plaintiff. For example, a portable X-ray is ordered in an intensive care unit on a young, otherwise healthy patient recovering from pneumonia. After the technician leaves, it is found that the patient has a fractured rib. This is not an ordinary or expected complication of an X-ray. There are no explanations for the injury other than mishandling, and the defendant was responsible for the patient's well-being at the time the injury occurred.

The following cases are cited as examples to the extent of this doctrine-

In *Gian chand v. Vinod kumar Sharm*[23] it was held that shifting of the patient from one ward to another despite requirement of administering immediate treatment resulting in damage to the patient's heath then the doctor or administrator of the hospital shall be held liable under negligence.

Jagdish Ram v. State of H.P[24], it was held that failure to provide the anesthetist with information about the amount of anesthesia and allergies of the patient resulting of the overdose of anesthesia and the patients subsequent death as a result was negligence and the doctor was held liable for the same. Invoking Res Ipsa Loquitur- Where the negligence is evident, the principle of Res Ipsa Loquitur operates and the Complainant does not have to prove anything as the thing (Res) proves itself. In such a case it is for the Respondents to prove that they had taken care and done their duty to repel the charge of negligence.

THE PROPOSED MODEL

[23] *Gian Chand v. Vinod Kumar Sharma , AIR 2008 HP 97*
[24] Jagdish Ram v. State of H.P 2008 ACJ 433

The following is the proposed model which has been suggested to be put in place while exercising the doctrine of Res Ipsa Loquitur.

1. Under all circumstances where the defendant has exclusive control, a pre-emptive assumption may not be taken to say that the defendant is guilty.
2. The plaintiff's demand must be viewed in terms of the circumstances involved. It cannot be that it be blindly assumed that the plaintiff has to be responsible for every act of the defendant.

Thus, it can be said that the doctrine of Res Ipsa Loquitur does not completely satisfy the conditions to make the defendant negligent prima facie and must be verified before application.

QUANTUM OF COMPENSATION

The final critical issue that comes to the foray at the outcome of every case of medical negligence is to decide the quantum of compensation awarded to the plaintiff. The major ambit of this is covered under the Motor Vehicles Act 1988. However, before awarding any compensation the court needs to be sure beyond reasonable doubt that it is 'Just compensation.'

Just Compensation

Till date there has not been a tangible definition of what can construe to be just compensation. The major definition and clarity was achieved in the case of *Sarla Verma and Others v Delhi Transport Corporation and Another.*

The judgement held- *"Compensation awarded does not become 'just compensation' merely because the Tribunal considers it to be just. Just compensation is adequate compensation which is fair and equitable, on the facts and circumstances of the case, to make good the loss suffered as a result of the wrong, as far as money can do so, by applying the well settled principles relating to award of compensation"*[25] The judgement also emphasised about the importance such

[25] Sarla Verma and Others v Delhi Transport Corporation and Another. (2011) 4 SCC 689.

compensation being consistent and uniform, that subjectivity should be limited and even about the equality in treatment.

In light of the various judgements two methods emerged for deciding the quantum of compensation. The following analysis is given to ascertain which is more viable for the purpose of compensation.

Multiplier Method

The method establishes a relation between the average losses of earnings of an individual with the average life expectancy. The major argument in favour of this method is that it ensures uniformity and consistency. It determines the amount of compensation by subtracting the amount of money the plaintiff would have spent on himself and correlates it to the number of unproductive years thus arriving at a standard amount.

Lump Sum Method

In this method compensation is awarded on a lump sum basis. It is also seen to be punitive in nature for the following reasons:

1. It sets a very strong example to society that any such incidence will be dealt with the utmost strictness.
2. It also makes an adequate amount of money available to the survivor to live a reasonable life in the absence of the deceased.

Validity of Both Models

It is important to note that the Lump Sum method is by nature arbitrary. It can be said that it promotes arbitrariness as there is no fixed way compensation to be calculated. Whereas, on the other hand the Multiplier Method establishes a statistical correlation which at times may not be adequate but is certainly not arbitrary. On the outset therefore it can be said that the Multiplier Method promotes objectivity and also the speedy disposal of cases and therefore can be considered as a better alternative to the Lump Sum Method.

Limitations of the Multiplier Method

The foremost limitation which can be viewed in the method is that in the process of maintaining uniformity it treats different situations alike- Example- A no fault motor vehicle accident victim and loss of human life by medical negligence of doctors. An important case which comes to the forefront is of *Nizam Institute of Medical Sciences v Prasanth S. Dhananka and Others*[26]*; Supreme Court of India;* it involved a student of engineering being operated on by the hospital and as a result of negligence being completely paralysed. In this case the Supreme Court rejected the application of the Multiplier Method. It was held: -

"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 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"[27]

It was said that there should be limited emphasis on sympathy while awarding compensation but in such cases where the person has lost almost complete control over his body making him represent a different equation even with his family, the Multiplier Method can in no way provide adequate and just compensation to the people.

Proposed Model

It can be said that the Multiplier Method must be exercised within certain conditions and not in its absoluteness. The conditions are listed as:

1. Mathematical precision must be used to establish broad parameters and not achieve exact accurate results. The purview of compensation must be in those broad parameters.
2. There should no particular straight jacket formula and along with the discretion exercised by the courts there should be room left for treating each and every case differently.
3. Precedents must be used as a broad framework and not as straightjacket solutions.

[26] Nizam's Institute of Medical Sciences v. P.S.Dhananka; (2009) 6 SCC 1

[27] Nizam Institute of Medical Sciences v Prasanth S. Dhananka and Others; Supreme Court of India

4. Where circumstances demand so, awarding compensation can be seen as a deterrent and therefore used in a punitive manner.

CONCLUSION

Through the medium of this paper, various informative and overlapping areas in the field of medical negligence came to the foray. The following are the major observations:

Firstly, the duty of care is owed to the plaintiff by the medical practitioner in various circumstances, even while taking up the case and the administration of treatment. The existence of a Living Will does not absolve the practitioner of the duty that is owed by him. In cases of minors and of unconscious people certain exceptions are allowed but they are not outside the ambit of the duty of care. Secondly, to establish the exact 'Reasonable Standard', customary practices along with certain factors which may be out of control of the defendant must be taken into account. The Bolam Test may no longer stand valid in light of current circumstances due to its nature being arbitrary. To replace the Bolam test, customary practice along with other factors must be used. Thirdly, the role of consent and disclosure, with particular emphasis on the importance of informed consent must be taken into account. A certain degree of independence should be given to the profession to determine its own standard along with a certain degree of discretion to the practitioner.

Fourthly, the extent to which the doctrine of *Res Ipsa Loquitur* can be used is limited by the extent to which it can be established that the defendant had exclusive control over the circumstances and therefore the issue of the doctrine favouring the plaintiff is kept to be verifiable. Fifthly, the exact method to determine the quantum of compensation, being the multiplier method, has been determined. It is noted that the multiplier method also has its fallacies and therefore needs to be practised with certain conditions.