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Criminal Accountability of Healthcare Providers in ART Clinics

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Criminal Accountability of Healthcare Providers in ART clinics

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I. Introduction

Health and happiness go together. Happiness is a futile dream without a health. A sound mind needs a sound body; the one reacts to the other. Medical practitioners are indeed, the most significant class of service providers. Medical practitioner is a word, when heard by anyone can immediately develop respect in the heart. It is the noblest profession in all the professions available throughout the world.

Being a medical practitioner is having the responsibilities more, than the privilege. Medical practitioner is considered as a highly responsible person because he can save a life of human being, when a patient is in critical condition. Medical practitioners have the highest responsibility over the life of a patient. There are many critical situations, when medical practitioner plays the most significant role in saving life of the patient. It is the most demanding profession throughout the globe. The profession is just for helping the community, rather than what you can gain from the community.

Every law is a double-edged sword. The Consumer Protection Act, 1986, under which the medical practitioners are also held to be liable for deficiency in service is no exception to this rule. In 2006 the Supreme Court in ***Jacob Mathew case***[1] while laying down certain guidelines to protect medical practitioners from unjust prosecution, had observed that these guidelines will hold good till the Government frames guidelines in consultation with the Indian Medical Association. Four years down, no guidelines have been framed by the Government and in recent another judgment of the Supreme Court in ***Martin F. D'Souza v. Mohd. Ishfaq***[2], the Court has reiterated the need for guidelines to strike a balance between the interests of patients and that of medical practitioners against unjust prosecution. The Court in this judgment has also laid down certain additional safeguards to this end.

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[1] Jacob Mathew v. State of Punjab, (2005) 6 SCC 1: 2005 SCC (Cri) 1369.
[2] (2009) 3 SCC 1

In ***Indian Medical Association v. V.P Shantha***[3] the Supreme Court clarified that the services rendered by a medical professional are services within the definition of the Consumer Protection Act and therefore medical practitioners are also liable for deficiency in service under the Act. Other than civil liability under the Consumer Protection Act, medical professionals can also be prosecuted for criminal negligence under the provisions of the Penal Code, 1860. The judgment in ***V.P Shantha***[4], while definitely being a shot in the arm to patients, is also turning out to be a weapon being abused and wielded indiscriminately by certain patients. As is the case with most laws, there is need to frame guidelines, to strike a balance between the need to protect patients and the need to protect medical practitioners from undue harassment and humiliation. As is the case with most laws, the Government has not come forward with any guidelines, and the difficult task of striking a balance has been left to the courts of law.

2. LAWS AND GUIDELINES RELATED TO ART CLINICS

As per Section 2(c) of the Act, an ART clinic is defined as: *"Any premises equipped with requisite facilities and medical practitioners registered with the National Medical Commission for carrying out ART procedures."* Under Rule 3(1), ART clinics are classified into two levels based on the services they provide. The Act stipulates that the executive head of an ART clinic is liable for any offences committed under its provisions, unless they can demonstrate lack of knowledge or due diligence in preventing such violations. The law underscores the necessity for ART clinics to establish Standard Operating Procedures (SOPs) to ensure compliance. The impact of the Act was evident in the case of *Rakhi Bose v. Union of India (2022)* before the Kerala High Court. A married couple, who had undergone oocyte retrieval in 2014 and preserved their embryos, sought permission to transfer the frozen embryos to another hospital for continued treatment. However, the newly enacted Act imposed restrictions on embryo transfers, leading the hospital to deny the request. The couple approached the Court, arguing that the law should not create undue hurdles for those seeking ART services. The Court ruled that the primary objective of the Act was to regulate and supervise ART clinics while ensuring ethical practices, not to obstruct access to ART. Consequently, the Court permitted the embryo transfer. The Act mandates the registration of ART clinics, requiring them to apply within 60 days of the establishment of the National

[3] (1995) 6 SCC 651
[4] (1995) 6 SCC 651

Registry. Initially, the registration certificate is valid for five years, with provisions for renewal for an additional five years.[5]

A recent case in Tamil Nadu, where a 16-year-old girl was allegedly coerced into selling her oocytes using a forged Aadhaar card, highlights the pressing need for strict regulations. With the growing number of ART clinics and the rising demand for ART services, the Legislature has sought to address ethical concerns through this Act. However, its constitutional validity is currently being challenged in the Delhi High Court. Petitioners argue that the Act is discriminatory, as it primarily covers commissioning couples and women while excluding single men, LGBTQ individuals, live-in couples, and those with secondary infertility. The *Assisted Reproductive Technology (Regulation) Act, 2021*, along with the *Surrogacy (Regulation) Act, 2021*, continues to face legal scrutiny. The coming years will determine whether these laws strike the right balance between regulation, accessibility, and individual reproductive rights.

2.1. MAJOR DUTIES OF ART CLINICS

Chapter IV of the Act and the Rules outline the responsibilities of ART clinics, including[6]:

2.2. **Written Consent and Use Restrictions**: ART clinics must obtain written informed consent from individuals undergoing ART procedures. Cryopreservation of embryos or gametes requires explicit written instructions from all concerned parties. Clinics are prohibited from using reproductive material contrary to the provisions of the Act.

2.3. **Maintaining Accurate Records**: Clinics must keep detailed records for at least ten years. After this period, records must be transferred to the National Registry. Additionally, records must be accessible for inspection by the National/State Board and the National Registry. If a clinic is involved in any legal proceedings, its records must be preserved until the case is resolved.

2.4. **Other Responsibilities and Prohibitions**: The Act imposes strict guidelines on the use of human gametes and embryos, particularly regarding **Preimplantation Genetic Diagnosis (PGD)**. Notably, it prohibits clinics from offering procedures that allow parents to

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[5] Jim Buchanan, Baby M & Surrogate Motherhood: A Resource Guide, Vance Biblios, 1987.

[6] Illegal Oocyte Sale: 4 Private Hospitals in Tamil Nadu to Face Action for Violations, *The Hindu* (July 14, 2022), https://www.thehindu.com/news/national/tamil-nadu/illegal-oocyte-sale-4-private-hospitals-in-tamil-nadu-toface-action-for-violations/article65638562.ece.

predetermine the sex of a child. The Rules further specify staffing requirements, necessary equipment, and mechanisms for grievance redressal.

Liability of Medical practitioners for Negligence: Civil Law

(I) Evolution of medical professional's liability in tort: The Bolam rule

The issues relating to tort liability of professionals such as medical practitioners, lawyers, architects, financial advisers and many others assume special significance because of two main reasons. First, the professional expertise of these individuals is of vital importance for complexities of modern day social interactions arising on account of changes relating to business and trade transactions, living styles and ideas of comfort, leisure and pleasure activities. Second, the higher stakes involved in respect to the bodily, property and financial interests of the clients that such professional expertise entails. Therefore the relationship between the aforesaid professionals and the clients requires a constant and close scrutiny.

Such a scrutiny would be premised mainly upon the following considerations:

a. The principle of holding out;

b. The principle of reaping higher benefits in the form of fees and professional charges;

c. The principle of trustee relationship and greater expectation and dependence of the clients;

d. The principle of better ability to control the standards of the activity/enterprise; and

e. The principle of better position in respect of distribution and socialisation of losses.

The issues relating to liability of the medical profession, both individuals and corporate entities assume special significance in the present context. In this respect medical profession would be focused upon in the context of contemporary social realities in which the medical need far exceeds the availability of skilled professionals and also the corporatisation of medical profession that implies much better access to the most advanced technologies as well as the best skilled manpower.

(II) Weakening authority of Bolam case in common law jurisdictions

The limits imposed on medical negligence liability by *Bolam case*[7] have been put to test in a series of decisions in several other common law jurisdictions such as Australia, Canada and the United States and even in the United Kingdom itself. Although *Bolam case*[21] remains the leading authority in medical negligence cases, but in at least three areas the authority has been considerably weakened in the recent years:

(i) **Duty to disclose risks and provide information and advice**

In ***Rogers* v. *Whitaker***[8] the Australian High Court while affirming a decision of the New South Wales Supreme Court laid down that a medical practitioner has a duty to warn the patient of a material risk inherent in the proposed treatment. A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it.

The aforesaid duty towards the patient of answering all his questions about treatment and risk truthfully, had never been addressed to in the Bolam approach. Thus, in the field of non-disclosure of risk and the provisions of advice and information the decision in *Rogers*[9] has virtually discarded ***Bolam***.[10] Yet another Australian High Court decision ***Rosenbreg* v. *Percival***[11] has extended the decision of *Rogers* in respect of a medical practitioner's duty to inform the patient of the inherent risks associated with the proposed treatment. The Court in *Rosenbreg case* endorsed a subjective causation test in assessing whether the patient would have avoided the risk if it had been disclosed.

(ii) **The court's duty to embark on a risk-benefit analysis to assess the acceptability of treatment**

In ***Bolitho v. City and Hackney Health Authority***[12] the Court got away from yet another aspect of ***Bolam case***[13] that could be described as an "no escape route" for the medical practitioner's liability. Lord Browne Wilkinson's following ruling is notable in this respect:

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[7] Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582 : (1957) 2 All ER 118

[8] (1992) 109 Aus LR 625 : 1992 ALMD 6993

[9] (1992) 109 Aus LR 625 : 1992 ALMD 6993

[10] Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582 : (1957) 2 All ER 118

[11] 2001 HCA 18 : (2001) 75 ALJR 734

[12] (1998) 1 AC 232 : (1997) 3 WLR 1151 : (1997) 4 All ER 771 (HL).

[13] Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582 : (1957) 2 All ER 118

The court is not bound to hold that a defendant medical practitioner escapes liability for negligent treatment or diagnosis just because he procures evidence from a number of medical experts who are genuinely of opinion that the defendant's diagnosis or treatment is in accordance with sound medical practice. 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.[14]

(iii) **Patient's right to make informed choice**

The Supreme Court of Canada in ***Reibl v. Hughes***[15] related the medical practitioner's duty to warn the patient based on the patient's right to know the material risk, a right which in turn arises from the patient's right to decide for himself or herself whether to submit or not to the proposed medical treatment.

The human right debate was carried much farther by Kirby, J. in ***Rosenbreg case***[16] when he equated disclosure of risk rule to "a recognition of individual autonomy that is to be viewed in the wider context of basic human rights and human dignity". The aforesaid developmental trends are indicative of the focus shifting towards the patient's side that in effect would trigger a movement in the direction of a higher duty of care for the medical profession.

Persuasion of Bolam Test in India

In India, Bolam test has broadly been accepted as the general rule. In ***Achutrao Haribhau Khodwa v. State of Maharashtra***,[17] the Supreme Court held that "The skill of medical practitioners differs from one medical practitioner to another. The nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a medical practitioner if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with

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[14] (1998) 1 AC 232 at pp. 241 G-242 B: (1997) 3 WLR 1151 : (1997) 4 All ER 771 (HL).
[15] (1980) 114 DLR 3d 1 : (1980) 2 SCR 880 (Can SC)
[16] Rosenbreg v. Percival, (2001) 75 ALJR 734 : 2001 HCA 18
[17] (1996) 2 SCC 634

regard to the course of action to be taken by a medical practitioner treating a patient, but as long as a medical practitioner acts in a manner which is acceptable to the medical profession and the Court finds that he has attended on the patient with due care skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the medical practitioner to be guilty of negligence.[63] In cases where the medical practitioners act carelessly and in a manner which is not expected of a medical practitioner, then in such a case an action in torts would be maintainable.

Role of Informed Consent in Medical Practice

Informed consent is a process for obtaining permission before conducting a healthcare intervention on a person. A health care provider may ask a patient to provide a prior consent for the purpose of medical treatment, or a clinical researcher may ask a research participant before enrolling that person into a clinical trial. Informed consent is being collected by the medical practitioners according to guidelines of medical ethics and research ethics. An informed consent can be said to have been given based upon a clear appreciation and understanding of the facts, implications, and consequences of an action. To give informed consent, the individual concerned must have adequate reasoning faculties and be in possession of all relevant facts. Impairments to reasoning and judgment that may prevent informed consent include basic intellectual or emotional immaturity, high levels of stress such as Post Traumatic Stress Disorder (PTSD) or a severe intellectual disability, severe mental illness, intoxication, severe sleep deprivation, Alzheimer's disease, or being in a coma.

The concept of informed consent has been optimized according to the cultural. For example, people from Mediterranean and Arab appear to rely more on the context of the delivery of the information, with the information being carried more by who is saying it and where, when, and how it's being said, rather than *what* is said, which is of relatively more importance in typical western countries. The informed consent doctrine is generally implemented through prevailing healthcare practice, pre-operation discussions with patients and the use of medical consent forms in hospitals. However, it does not means that it will necessarily give the patient an opportunity to weigh and respond to the risk.

Criteria of Valid Informed Consent

Generally speaking the informed consent requires discussion of the following:[18]

- **i.** The patients diagnosis
- **ii.** The nature and purpose of a proposed treatment or procedure
- **iii.** The risks and benefits of a proposed treatment or procedure
- **iv.** Alternatives and associated risks and benefits
- **v.** The risks and benefits of not receiving or undergoing a treatment or procedure
- **vi.** The special precautions required postoperatively
- **vii.** What the medical practitioner recommends

For an individual to give valid informed consent, legally three components must be present: disclosure, capacity and voluntariness.

- **i.** Disclosure requires the researcher to supply the subject with the information necessary to make an autonomous decision; theinvestigators must ensure that subjects have adequate comprehension of the information provided. This latter requirement implies that the consent form be written in lay language suited for the comprehension skills of subject, as well as assessing the level of understanding.
- **ii.** Capacity pertains to the ability of the subject to both understand the information provided and form a reasonable judgment based on the potential consequences of his/her decision.
- **iii.** Voluntariness refers to the subject's right to freely exercise his/her decision making without being subjected to external pressure such as coercion, manipulation, or undue influence.

Ethical Elements of Informed Consent

There are two ethical justifications for the claim that medical practitioners should get consent from patients for tests or treatments. The first is based on the moral (and ethical) principle of autonomy, according to which a person has a right to determine the course of her own life and to be free (within limits that must themselves be justified) from interference by others. A central aspect of this right is a person's right to bodily integrity. It is impermissible for any person (including a medical practitioner) to invade or

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[18] Appelbaum PS et al :Informed Consent: Legal theory and clinical practice. Oxford University Press, New York, 1987. Catherine SweeKian TAY: Recent developments in informed consent: The basis of modern medical ethics, APLAR Journal of Rheumatology,2005; 8: 165–170

manipulate the body of another without permission. The second is based on the ethical principle of beneficence, according to which medical practitioners should act out of compassion or concern for their patients and aim at doing what will be best for them. Patients are typically the best source of information about what will make their lives go better.

At the international level there are six major hindrances to genuine informed consent:

i. Confusion and forgetfulness: some lay patient may have difficulties in remembering and understanding details relating to treatment comparisons. This may lead to the patient consenting without appreciating the risks.

ii. Cultural barriers: these may include presumed differences in the construction of personhood, language differences, and economic power.[19]

iii. Psychological forgetfulness by patient in respect of undesirable information especially related to risk.[20]

iv. Situational pressure on the patients may be occasioned when they are involved in several procedures.

Implicit forms of coercion such as the manner in which benefits are presented may threaten the patients. Procurement of informed consent may pose challenges to the medical practitioners assumed beneficence, thus leading to some resistance.

Implied Consent and Express Consent

This is the trust and empathy that a patient develops with his medical practitioner when he first comes in contact and due to this empathy he allows history and examination of himself. This empathy and trust forms the basis of implied consent and is the most commonly employed type of consent in general and medical setup. Implied consent is limited to the examination up to inspection, palpation, and auscultation, excluding examination of intimate parts (private parts). Whereas several European countries have defined the intimate parts, which generally include all the natural orifices of the body and genital parts including breast examination in females. In UK, oral cavity has been excluded from the list of intimate

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[19] Schoepf BG: Ethical, Methodological and Political Issues of AIDS Research in Central Africa; Social Science and Medicine 1991; 33(7): PP 749–763.

[20] Verheggen FW,et al; Informed Consent in Clinical Trials. Health Policy, National Center for Biotechnology Information,1996; 36(2): 131–153.

parts as for the requirement of DNA sampling.[21]The limitations of implied consent are that there is always a scope for misunderstanding between the medical practitioner and patient on what was actually implied by the patient's actions.

Procedure to Obtain Consent

Courts have determined it to be so broad and un-specific that it does not satisfy the duty of informed consent. The following should be included in "informed consent" form:[22]

i. Name and date of birth of pediatric patient

ii. Name and relationship to the pediatric patient/legal basis on which the person is consenting on behalf of the patient

iii. Description of the procedure in simple terms

iv. Disclosure of known adverse risk(s) of the proposed treatment specific to that procedure

v. Professionally-recognized or evidence-based alternative treatments to recommended therapy and risks

vi. Place for custodial parent or legal guardian to indicate that all questions have been asked and adequately answered

vii. Places for signatures of the custodial parent or legal guardian, dentist, and an office staff member as a witness

Judicial Discourse on Regulations of Clinical Trials - The Indian Context

Due to dearth of medical jurisprudence in India, one is duty-bound to analyse India's most assertive organ[23] i.e judiciary. Indian judiciary being "the sanctuary of Indian humanity" had in past decided on number of cases directly or indirectly dealing with the subject-matter.

The Supreme Court disposed of a writ petition dealing with ban on sale, production and manufacture of Quinacrine in form of pellets, on the grounds that the Government was progressively taking steps in this regard under Sections 10-A and 26-A of the Drugs and Cosmetics Act, 1940. This judgment illustrated the Supreme Court's viewpoint of intolerance towards clinical malpractices and its protective altitude in this regard.

The Government, however, languidly notified such change, and itwas urged

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[21] Mc Lay WDS: Clinical Forensic Medicine. Clinical Forensic Medicine (Cambridge New York, University Press, 3rd Edition, 2009): 38.

[22] Rajaram S. Parab vs. KalpanaDesai; 1998 (3) CPR 398, Para 13.

[23] A.M Ahmadi, "Judicial Process: Social Legitimacy and Institutional Viability", (1996) 4 SCC J-1, pp. 4-5.

to move swiftly in Lok Sabha. Also despite Quinacrine being banned in India through judicial orders, its continued prevalence is still reported in various parts, thereby reflecting the need for a stronger regulatory mechanism.[24]

Swasthya Adhikar Manch, Indore and another V. Ministry of Health and Family Welfare and others[25]- A Mile Stone Judgment

The court issued[26] direction for seeking information regarding malpractices in medical experimentations by government and non- government as well as by independent investigators.

It has been found by the court that certain measures have been taken to strengthen the regulation of medical experimentations that include amendment in the Rules specifying procedure to analyse the reports of serious adverse events including deaths occurring during medical experimentations and procedures for payment of compensation in case of trial related injury or death. The court extended the amendment in the rules specifying various conditions for conduct of medical experimentations, authority for conducting medical experimentation inspections and actions in case of non-compliance. By amendment, it is proposed that no Ethics Committee can review and approve any clinical trial protocol unless it is registered with the Central Drugs Standard Control Organisation and that in case of non-compliance, the registration can be suspended or cancelled. The Drugs and Cosmetics (Amendment) Bill, 2013 has been approved by the Government. The Bill has a separate chapter containing strict penal provisions relating to payment of compensation, Ethics Committee and certain other measures, which have been taken to strengthen regulation of medical experimentations. However, the proposed measures do not answer many issues particularly, with regard to the medical experimentations in respect of new chemical entities and so also the controlling and monitoring measures.

Conclusions and Suggestions

The substantial clinical autonomy of medical practitioners is essential to provide quality care for patients. In other words physicians should be free to make decisions about the care of the patient. It is in the best interests of the patient without unduly alarming restrictive laws, regulations and administrative requirements. Autonomy for medical practitioners is also

[24] A.I Democratic Women Assn. v. Union of India, (1998) 5 SCC 214.

[25] (2014) 14 SCC 788

[26] Swasthya Adhikar Manch, Indore and another v. Ministry of Health and Family Welfare and others, (2014) 14 SCC 788

pertinent to be safe-guarded from unnecessary interference. Professional autonomy is meant to pertain to care the patients. It does not mean that medical practitioners are free to do whatever they please. Professional autonomy is granted to medical practitioners by society. There is a corresponding responsibility on the part of medical practitioners to take into account the structure, resources and culture of the society of which they are a part.

In ***Martin F. D'Souza v. Mohd. Ishfaq***[27] the Supreme Court has recently directed the consumer and criminal courts of the country to first refer complaints relating to medical negligence received by them to a competent medical practitioner or committee of medical practitioners and to issue notice to the concerned medical practitioner or hospital against whom the complaint has been mad, only after such medical practitioner or committee reports that there is a prima facie case of medical negligence. This has far-reaching consequences for the medical negligence cases that may be filed in the Consumer Courts after the judgment was passed. In support of these directions, the Supreme Court relied strongly on the English case of ***Bolam v. Friern Hospital Management Committee***.[28]

In ***Martin F. D'Souza case***,[29] the complainant was suffering from renal failure, urinary tract infection and blood infection. He also had extremely high urea. This compelled the medical practitioner to take a "drastic measure" to save his life. He was prescribed a dose of amikacin, an antibiotic. This led to his hearing getting affected. He obtained an order favouring his claim against the medical practitioner from the National Consumer Disputes Redressal Commission, New Delhi. The medical practitioner appealed against this decision and the Supreme Court allowed the appeal. The judgment reveals that the harassment of medical practitioners due to the filing of frivolous complaints in consumer and criminal courts and the need to shield from operating with the fear of legal action weighed heavily with the Court. The Court also greatly relied on its earlier decision in ***Jacob Mathew v. State of Punjab***.[30] After reviewing a series of judgments, including many of its earlier judgments on medical negligence, the Court finally issued the following direction: (Martin F. D'Souza case,[31] a complaint is received against a medical practitioner or hospital by the Consumer Forum or by the criminal court then before

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[27] (2009) 3 SCC 1 : (2009) 1 SCC (Cri) 958
[28] (1957) 1 WLR 582 : (1957) 2 All ER 118
[29] (2009) 3 SCC 1 : (2009) 1 SCC (Cri) 958
[30] (2005) 6 SCC 1 : 2005 SCC (Cri) 1369
[31] (2009) 3 SCC 1 : (2009) 1 SCC (Cri) 958at p. 33 para 106

issuing notice to the medical practitioner or hospital against whom the complaint was made the Consumer Forum or the criminal court should first refer the matter to a competent medical practitioner or committee of medical practitioners, specialised in the field relating to which the medical negligence is attributed, and only after that medical practitioner or committee reports that there is a prima facie case of medical negligence should notice be then issued to the medical practitioner/hospital concerned. This is necessary to avoid harassment to medical practitioners who may not be ultimately found to be negligent.

The Suggestions

The Supreme Court, while deciding ***Martin F. D'Souza***,[32] was bound by its own observations in Vinitha Ashok, that ultimately any expert opinions produced before it must be able to withstand logical analysis before being accepted. It seems to have emphasised by the Court a need to protect medical practitioners from the harassment caused to them as a result of receiving notices from Consumer Courts. In cases falling under the jurisdiction of the Consumer Courts, of course, there is no question of medical practitioners being arrested, in the same way that they may be if a complaint is made before a criminal court. The Court may have fallen back on the argument that it is of critical importance to society that medical practitioners be doing their duty, rather than having to abandon it to attend court proceedings. Anyhow such an opinion of the court enables medical practitioners to exercise their judgment with autonomy and it seems to be a positive step.

The Court might have referred to and relied on its judgment in ***J.J Merchant (Dr.) v. Shrinath Chaturvedi***.[33] In that case, the Court expressly held that a speedy trial is a must in proceedings before the Consumer Courts. The Court held that Consumer Courts may or may not examine medical practitioners or experts, and may rely upon the mere statements of medical practitioners or experts. If witnesses are to be examined, they could be examined by the Commissioner appointed by the court. If cross-examination is necessary, the questions could be put in writing and they could be replied by medical practitioners on affidavits. Video conferencing and telephone conferencing can also be used to cross-examine medical practitioners. The Commissioner appointed by the Court could visit the working place of the expert to be examined, to examine him/her.

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[32] (2009) 3 SCC 1 : (2009) 1 SCC (Cri) 958

[33] (2002) 6 SCC 635

However, there is no running away from the fact that while the Supreme Court endorsed the ***Bolam***[34] test in Jacob Mathew,[35] ***Martin F. D'Souza*** and other cases, it also adopted the "Bolitho rule" in ***Vinitha Ashok***,[36] placing the important caveat that the opinions given in favour of the medical practitioner must be capable of withstanding logical analysis. This being the case, the most that a court can give medical practitioners by way of protection from frivolous claims, is the assurance that they will be exempted from attending court even if a complaint is made against them in a Consumer Court. Beyond that, it is difficult to see how any consumer complaint against a medical practitioner can be summarily dismissed on the basis of a "committee report", without the patient being given a chance to produce opinions of experts in favour of his case, without him being allowed to be heard, and without the court applying its judicial mind to the facts of the case. If the Court had held in ***Martin F. D'Souza***,[37] that instead of a committee reporting on whether medical negligence had been prima facie disclosed by the complaint, the complainant would have to produce his own evidence in the form of expert opinions in favour of his private criminal complaint case, as observed in ***Jacob Mathew case***[38] it would, to some extent have been more equitable. However, the burden cast upon the patient would still be somewhat disproportionate, as it is possible to imagine a case where even though a patient does not, or cannot produce a single opinion in favour of his case, the court still considers that the respondent medical practitioner's explanation, the expert opinions the medical practitioner has produced in favour of his case, and the cross- examination of these experts all show that in fact, there is no responsible or reasonable body of opinion to support the medical practitioner's case, and he is clearly guilty of medical negligence. The court would be justified in coming to a finding of medical negligence on this basis, and it would be wrong to deny the court the right to come to such a conclusion, just because the patient could not produce a favourable opinion.

Thus, calling upon the patient himself to produce credible opinions in favour of his case, instead of making the entire case dependent upon "committee reports" is an option, but it has its own problems. In conclusion, it is submitted, with all due respect, that the Supreme Court's directions in

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[34] (1957) 1 WLR 582 : (1957) 2 All ER 118
[35] (2005) 6 SCC 1 : 2005 SCC (Cri) 1369
[36] (2001) 8 SCC 731
[37] (2009) 3 SCC 1 : (2009) 1 SCC (Cri) 958
[38] (2005) 6 SCC 1

Martin F. D'Souza case[39] are unfair to the patients, while tilting the balance in medical negligence cases in favour of medical practitioners. The Court may, instead, have exempted medical practitioners from appearing in court, but making the whole of the patient's case dependent upon "committee reports", by blind adherence to the ***Bolam*** rule may lead to abuse of the judicial process and loss of faith in the consumer justice disposal system. It is hoped that a future ruling by a larger Bench of the Court will once again set right the balance.

[39] (2009) 3 SCC 1 : (2009) 1 SCC (Cri) 958

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