INDIAN MEDICAL ASSOCIATION v. V.P. SHANTHA (1995) 6 SCC 651

*Debkanya Roy Choudhary**
*Radhika Rajagopal**

"Justice is giving to every man his due"

INTRODUCTION

The basic issue addressed in this landmark judgment is that of the applicability of the Consumer Protection Act, 1986, to the medical profession, hospitals, dispensaries and paramedical services. The Consumer Protection Act, 1986,[1] was the outcome of the adoption by the United Nations of a basic framework for the governments of the third world countries to strengthen consumer protection policies.[2] For this purpose, the COPRA provides for establishment of various quasi-judicial machinery like the District, State and National commissions to provide a speedy remedy to consumers.

Legally a doctor is liable in an action for negligence if he fails to exercise the care and skill reasonably expected of a competent medical practitioner. This has been the basis of tortious liability for medical practitioners. The radical departure is made by COPRA in that no court fee is needed to be paid and provision is made for expeditious disposal of complaints, thereby seeking to provide effective remedy to the consumers.

Till the pronouncement of the judgment, the accountability of medical professionals and indemnification of aggrieved parties had become a controversial issue. The decline in the fiduciary character of the doctor-patient relationship coupled with the commercialisation of the services of the medical establishment had led to the evolution of the concept of the patient as a consumer. Resultantly, the issue of interpreting the statute to allow for medical services to be included within the scope of COPRA was largely for the purpose of providing quick justice to patients having grievances as consumers of medcial services.

The Supreme Court through its judgment on 13-11-1995 pronounced by a three judge bench comprising of Justices Kuldip Singh, S.C. Agrawal and B.L. Hansaria have dealt with the controversy with COPRA being made applicable to the medical services.

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* I Year B.A., LL.B. (Hons.), NLSIU.

1 Henceforth referred to as COPRA.

2 On 09/04/1985, the General Assembly of the U.N. passed the Consumer Protection Resolution ND 39/248.

THE BROAD ISSUES EXAMINED

1) The definition of service in the explanatory part of section 2(1)(0) of COPRA and the medical services.

2) Medical services whether excluded under the exclusionary part of section 2(1)(0) of COPRA.

3) The competence of the remedial bodies under COPRA to address cases of medical professional negligence.

1) Definition of Service under Section 2(1)(0)[3] explanatory part and the medical services

This issue was considered by the court keeping in mind the object of the Act and the definition of consumers envisaged under the Act.

As interpreted earlier in *Luknow Development Authority v. M.K. Gupta*,[4] the court held that the object of the Act was to recognise that a consumer is a person who is not only involved in purely commercial transactions as the availer of goods and services as in buying and selling, but is also involved in such activities which are not strictly commercial in character and in which some benefits are conferred on the consumer. The words 'any' and 'potential' in the definition of service were therefore given the widest amplitude considering thus that hospitals are often managed by corporate entities and treatment costs are translated into profits.[5] As such, medical services may be included in the wide interpretation of 'any service' made available to 'potential users' if a minimum degree of the professed skill is to be ensured.

The crux of the second objection to the applicability of COPRA to medical services was that there is a distinction between professions and occupations and the reason why professions cannot be made subject to legal scrutiny is because in professions, success cannot be achieved in every case and success and failure depend often on factors beyond the control of the professional person.[6] The court countered this by highlighting that the success or failure of the individual cases were not being made subject to scrutiny, but a minimum degree of professional skill and

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3 Definition of services in section 2(1)(0) service means services of any description which is made available to potential users and includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction entertainment, amusement or the purveying of news or other information, but does not include rendering of any service free of charge or under a contract of personal service.

4 (1994) 1 SCC 243.

5 In *Dr. C.S. Subramaniam v Kumaraswamy*, 1994 CCJ 475, the court held that whether there is a special contract or not between them is not really material but there is always an implied term to act at all times in the best interest of the patients.

6 *IMA v. V.P. Shantha*, (1995) 6 SCC 657 at 665.

care expected reasonably of a professionally competent person in the discharge of his duties was being regulated. The standard of reasonable skill and care was already a principle of tortious liability which as been applied to various professions and the medical profession could not claim immunity.[7]

The third objection that had been raised to the applicability of COPRA to medical services was that the Medical Council of India[8] has already been statutorily assigned the task of regulating professional conduct. The statutory body is however, a nearly dysfunctional body and hence the victim cannot obtain redress there.

2) Medical services if excluded under the exclusionary part of definition of service in section 2(1)(0): [9]

The issue of whether medical service may be excluded under section 2(1)(0) consists of two different exclusionary provisions:

(1) rendering of personal service and

(2) rendering of service free of charge.

1) Rendering of personal service:

A contract of personal service has been specifically excluded from 'service' under the ambit of section 2(1)(0) of COPRA. It had been contended that the relationship between a doctor and a patient is in the nature of personal service. The court held that a contract of service implies relationship of a master and servant or more specifically involves an obligation to obey orders in the work to be performed and to its mode and manner of performance.[10] The distinction was drawn between the 'contract of personal service' and the 'contract for personal services'. The latter implies a contract whereby one party undertakes to render services, for example, professional or technical services in the performance of which he exercises profes-

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7 *Ibid.* The court however, had not taken up another conspicuous reasoning to justify the stand. Reference had been repeatedly made to Jackson and Powell on Professional Negligence, paras 1-01 and 1-03, 3rd ed., stating that among other occupations, accountants, insurance brokers and architects had been accorded the status of professionals. Since these professions had been mentioned in the inclusionary part of the definition service in section 2(1)(0), obviously the inclusionary part of the definition had not intended to make only occupation and not professions the subjects of COPRA and the occupation - profession, distinction breaks down there.

8 Per Agrawal J., at p. 666. Further the very fact that the Medical Council of India exists for the purpose of regulation of the profession indicates that the profession can be made subject to scrutiny, notwithstanding the argument why professions cannot be made so subject. In this case, the consumer fora would be enforcing accountability of the profession which was supposed to have regulated itself through the Medical Council of India. The competence of the consumer fora to do becomes another issue.

9 Exclusionary part of Section 2(1)(0). Service... does not include the rendering of any service free of charge or rendering of personal service.

10 Per Agrawal, J., at p. 672.

sional and technical skill according to his own knowledge and discretion, which is what the rendering of medical services generally is.[11]

2) Rendering of service free of charge:

The service rendered free of charge by a medical practitioner attached to or employed by a hospital, whether governmental or non-governmental, or a nursing home, or a health centre or a dispensary where no charge is made from any person availing of such service and all patients (rich and poor) are given free service is excluded by the exclusionary provision of section 2(1)(0).

The court held the above after rejecting the contentions that nominal registration fee or the medical officer's salary for employment in the hospital (since there is no direct nexus between the payment of salary to the medical officer by hospital administration and the person to whom the service is rendered) or, the taxpayers' money contributing to functioning of government hospitals or health dispensaries (since there is no concept of quid pro quo in tax), would constitute consideration for the free service rendered in such cases.[12]

The exclusionary part of the definition in section 2(1)(0) does not obviously cover service rendered at a non-governmental hospital or nursing home where charges are required to be paid by persons availing such services and therefore, falls within the purview of the expression services as defined in the Act.

It was held that services rendered at a government hospital, health centre or dispensary where such services are rendered on payment of charges and also rendered free of charge would fall within the scope of the Act, irrespective of the fact that the service is rendered free of charge to persons who do not pay for such services, because, in view of the overall object of the Act, the persons belonging to the "poor class" who are provided services free of charge were held to be the beneficiaries of the services which is hired or availed of by the paying class.

However in the definition of consumers as under section 2(1)(d),[13] a person can become a beneficiary only with the approval of the person who has payed the consideration. In this case, there is no approval which may thus be obtained and

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11 Though the court has refrained from commenting on it, the raising of both arguments of inapplicability of COPRA because of rendering of medical services being a profession and that of the same part taking the nature of contract of personal service seem contradictory to each other since a profession necessarily implies a certain minimum level of independent decision making greater than found in any occupation and so cannot thus be a contract of personal service.

12 Per Agrawal, J., p. 677.

13 Section 2(1)(d) : 'Consumer' means any person who -

i omitted,

ii hires or avails of any services for a consideration which has been paid or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such services... when such services are availed of with the approval of the first mentioned person.

hence it is doubtful whether the concept of beneficiaries can be extended as has been done. If the concept of beneficiaries has thus been extended, then the court should not have had any hesitance in holding that the people who avail of free services when such services are not paid for by any other recipient of the service can also be made consumers since they are the beneficiaries of the taxpayers, albeit without their approval.

3) The competence of remedial bodies under COPRA to address cases of medical professional negligence

The contention that had been raised against the applicability of COPRA to medical profession has been that due to the composition of the District Forum, State Commission and National Commissions by laymen, complex medical issues would not be determined satisfactorily. The court held[14] that most cases of obvious negligence which do not raise any complicated medical issues can be dealt by the consumer courts speedily. Besides the consumer courts do not oust the jurisdiction of the Civil Courts, where complex medical issues accompanied by expert evidence may be decided.

The judgement does not create any change in the substantive law governing claims for compensation on the ground of negligence and the principles which apply to determination of such a claim before the civil court would equally apply to consumer disputes before the Consumer Dispute Redressal Agencies.

SITUATION IN OTHER COUNTRIES

In the United States of America and United Kingdom the usual mode of claims against doctors is through negligence actions against them through which compensation may be obtained. Complaint is central to this ethos and the notion that blame must be attributed and the injured party compensated has a high priority in the United States. This results in frequent litigations resulting, according to some, in the practice of defensive medicine, a form of medical practice which is more oriented towards the protection of the doctors' legal position than the patients' anticipated benefit as well as rise in medicare costs with an increase in premium for malpractice insurance. In the United Kingdom, the situation is different since the doctor has little direct contact with the patients and where fault and responsibility are underwritten by the state and the doctor is regarded as a public servant.[15] Hence, doctors in United Kingdom have little exposure to deterrence.

The New Zealand system, whereby a no fault compensation scheme operates to compensate the injured has evoked great support in United Kingdom. Medically, the requirement for compensation is that the injury resulted from 'medical or surgical' misadventure, a requirement that however causes difficulties in differen-

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14 Per Agrawal, J., p. 669.

15 Mason & McCall Smith, "Law & Medical Ethics", 161 (1991).

tiating between the result from the physiological progress of a medical condition and the injuries that specifically are results of misadventure.[16] However, this system although widely supported has little deterrence value.

CONCLUSION

The judgment has given rise to divergent views on the possible changes that might occur in the realm of medical services, it has been said that henceforth private doctors would increasingly seek insurance costs to meet the expenditure in the eventuality of award of damages and the arena of practising defensive medicine would begin.

Inspite of the possible disadvantages mentioned generally a greater transparency in the mode of treatment and surgery ought to occur. In a country like India, where the standard of medical service offered generally to a great cross-section of the people is low, the system of negligence action would have a greater deterrence value and thus ought to increase care in rendering of services. This becomes specially important where negligence is apparent per se. However the judgment is not comprehensive since it does not provide a guarantee that complicated medical issues would be dealt with effectively in the consumer fora, especially since the prerogative of taking action being with the complainant, the remedy through civil court would be obviously avoided. Another conspicuous lacuna in the judgment is not providing for any remedy where free medical services are concerned especially since the service offered by Government hospitals are far from perfect. The two presumptions operating with respect to that seem to be that the services rendered by the Government are free and the services rendered in the Government hospital are perfect. The reluctance of the court not to uphold the 'taxpayers' money consideration' contention is not understandable since though services in Government hospitals are free to the patients they are met from the taxpayers' money and doctors are paid for their services from the amounts contributed by the people.

There is a lack of provision in the judgment for any screening procedure at the stage of admission of a case. It is also suggested that the res ipsa loquitor principle[17] where the burden of proof is shifted on the doctor in cases of obvious negligence or where such an outcome could not have occurred but for the negligence of the doctor, can be made applicable in India.

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16 Dyer, "No fault compensation", (1988) 297 *British Medical Journal*, 939.

17 This principle was made applicable in the English case of *Cassidy v. Ministry of Health*, (1951) 1 All ER 574, where the patient underwent treatment to be cured of two stiff fingers but came out with four stiff fingers. This situation pointed towards the fact that the injury could not have happened but for the negligence of the doctor. *See* Mason & McCall Smith, *Law and Medical Ethics*, 221 (1991).